

Snake River Counseling Center  
2635 Channing Way, Suite B,  
Idaho Falls, ID 83404  
Phone 208.552.0490 Fax 208.552.2518  
[www.snakerivercounseling.com](http://www.snakerivercounseling.com)

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REGISTRATION INFORMATION

Please Print Clearly

Date of Exam: \_\_\_\_\_

Participants First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Education Level: \_\_\_\_\_

Gender: Male:  Female:  Marital Status: Single:  Married:  Divorced:

Address of Participant: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Guarantor Social Security #: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Who is responsible for this for this account: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer phone #: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Employee Assistance Provider: \_\_\_\_\_ Authorization # \_\_\_\_\_ Visits Approved: \_\_\_\_\_

Your doctor: \_\_\_\_\_ Referred by: \_\_\_\_\_

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Cultural Competency Awareness: So that I may more adequately address your mental health needs, please be sure to answer and initial the following three questions:

Are you proficient in English (i.e. are fluent enough to read, write, and speak on a daily basis) Yes\_ No\_

Do you use friends and or relatives for making your appointments? Yes\_ No\_

Do you have a need for an interpreter? Yes\_ No\_ *"If you answered 'yes' to this question please speak with the receptionist or counselor before proceeding further with filling out this packet. Thank, You."*

**Consent to Treat:**

I, the undersigned, have voluntarily entered into this treatment, or give my consent for the minor or person under my guardianship mentioned above, to enter into treatment at the offices of Snake River Counseling Center (SRCC). The rights, risks and benefits associated with the treatment will be explained to me and I will be allowed to and encouraged to ask questions as they arise throughout the process. I understand that the therapy may be discontinued at any time by either party. I understand the importance of being able to discuss this decision with SRCC as this will help facilitate a more appropriate plan of discharge for me. I certify that I have received a copy of my Participation Rights and certify that I have read, been allowed to ask questions, and understand its contents. I understand that as a recipient of services, I may get more information about these rights at any time. I consent to treatment and agree to abide by the above stated policies and agreements of SRCC.

Signature of Participant/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

(In a case where a participant is under 18 years of age, legally responsible adult acting on his/her behalf)

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#### FINANCIAL POLICY

Full payment is expected at the time of service. Snake River Counseling Center (SRCC) accepts insurance benefits. However, payment for non-covered services, deductibles, and copayments are to be made at the time of service. A statement of account will be sent to you for your records and to outline any balance following insurance payment/denial.

SRCC will bill your insurance for services provided. However, your insurance policy is a contract between you and your insurance company. SRCC is not a party to that contract. If your insurance company does not pay your claim within 60 days of submission, the balance will automatically be transferred to your account. Please be aware that some and perhaps all services provided may be non-covered and/or considered not reasonable or necessary by your insurance company, thereby leaving you responsible for full payment of the denied charges.

SRCC offers a sliding fee adjustment for patients and members of their families (defined below) who fall below 200% of the poverty guidelines as set forth in the Federal Register. Income levels are based on total "family" income, ("family" is defined below). The amount of the discounts and the income ranges for those discounts are fixed by the National Health Services Core in conjunction with the federal guidelines.

It is the policy of SRCC to charge for missed appointments, unless cancelled at least 24 hours prior to the appointment time. Please help us better serve you by keeping all scheduled appointments.

Medicare/Medicaid Certification: I certify that the information given me in applying for payment, under titles XVII and XIX of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed to process any claim on this or any related treatment/assessment. I request that payment of authorized benefits be made in my behalf directly to SRCC.

Champus/Champva Authorizations: I request payment of authorized benefits to SRCC on my behalf for any services furnished to me by SRCC or its staff. I authorize any holder of medical or other information about me to release to Champus and its agents any information needed to determine these benefits for related services.

Assignment of Benefits: I hereby assign and transfer to SRCC all insurance benefits payable to me by the insurance company(s) as listed above (and/or other policies if any) for services and costs incurred in connection with this treatment/assessment. I understand that this assignment of benefits shall be exclusively for the payment of charges for this treatment/assessment. I understand and authorize payments of such benefits to be made by the above named insurance company(s) directly to SRCC.

Release of Information: I hereby authorize SRCC or its staff to release the above named insurance company(s) any information concerning psychological procedures performed and the final diagnosis, as well as information on this form.

I hereby certify that the insurance/demographic information is complete and accurate. I understand that I am responsible for full payment for such charges by cash and/or by payment from assigned insurance benefits. In the event that full payment is not made as agree above, I agree to pay all costs and expenses incurred in collection of said charges including reasonable attorney's fees.

I have read, understood, and agreed to this Financial Policy

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

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Statement of General Policies

This form describes the confidentiality of your medical records, how this information is used, your rights, and how you may obtain this information.

**My Legal Duties**

State and Federal laws require that I keep your mental health records private. Such laws require that I provide you with this notice informing you of my privacy of information policies, your rights, and my duties. I am required to abide by these policies until replaced or revised. I have the right to revise my privacy policies for all mental health records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed to me during and evaluation, intake, or counseling session are covered by the law as private information. I respect the privacy of the information you provide me and I will abide by ethical and legal requirements of confidentiality and privacy of records.

**Use of Information**

Information about you may be used by the personnel associated with this clinic for diagnoses, treatment planning, treatment, and continuity of care. I may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation. Both verbal information and written records about a participant cannot be shared with another party without the written consent of you the participant and/or the participant's legal guardian or personal representative. It is the policy of this clinician not to release any information about the participant without a signed release of information except in certain emergency situations or exceptions in which participant information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other legal provisions provided by legal requirements.

**Duty to Warn and Protect**

When a participant discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the participant discloses or implies for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the participant.

**Public Safety**

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

**Abuse**

If a participant states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities, if a participant is the victim of abuse, neglect, violence or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

**Prenatal Exposure to Controlled Substances**

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. In the event of a participant's death, the spouse or parents of a deceased participant have a right to access their child's or spouse's records.

**Professional Misconduct**

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professionals actions, related records may be released in order to substantiate disciplinary concerns.

**Judicial or Administrative Proceedings**

Health care professionals are required to release records of participants when a court order has been placed.

**Minors/Guardianship**

Parents or legal guardians of non emancipated minor participants have the right to access participant's records. SRCC offers education to members and families about care options, participation and care, coping with behavioral health problems, and prognosis to increase positive outcomes and reduce the risks associated with non-participation.

**Other Provisions**

When payment for services are the responsibility of the participant, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the participants credit report may state the amount owed, the time frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third party payers are given information that they request regarding services to the participant. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about participants may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the participant or any identifying information, is not disclosed. Clinical information about the participant is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health profession must telephone the participants for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professionals first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the participant (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

#### Your Rights

You have the right to request to review or receive your medical files. The procedure for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopies) signature. If your request is denied, you will receive a written explanation of the denial. Records for non emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is 10 cents per page, plus postage.

You have the right to request to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if you do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right make a statement of disagreement which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing. If you desire this information be emailed to you, please speak with the clinician about the necessary details for confidential release. If you desire a written copy of this notice you may obtain it by requesting it from this clinician at this location.

#### Complaints

If you have any complaints or questions regarding these procedures, please contact this clinician. I will get back to you in a timely manner. You may

also submit a complaint to the US Dept. of Health and Human Services and/or the State of Idaho Bureau of Occupational licensing Board. If you file a complaint I will not retaliate in anyway.

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Direct all correspondence to: \_\_\_\_\_

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Participant's name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**NO SHOW/LATE CANCELLATION NOTICE**

Patients who fail to show up for their appointment(s) or fail to give twenty four (24) hour notice before canceling their appointments place an extra burden on Snake River Counseling Center (SRCC). Furthermore, since the appointment goes unfilled, this represents either a delay to see another patient or a financial burden to SRCC. Therefore SRCC has implemented the following policy:

Patients with "no show" or "late cancellation notice" appointments will be charged a fee of \$50.00. We will not reschedule your next appointment until fee is paid.

New patients who fail to show for their first appointment or reschedule/cancel with less than twenty four (24) hour notice will be required to sign this form before scheduling a second new patient appointment and paying in advance a deposit of \$50.00. If appointment is kept deposit will be credited to patient's bill.

I have read the above and agree to its conditions.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### Contact Permissions

I hereby give permission to authorized personnel including clinicians and administrative staff, to contact me by any of the methods checked below regarding scheduling appointments or other treatment issues; I understand that I may also receive correspondence for billing and other purposes through the postal service.

\_\_\_\_ Home phone      # \_\_\_\_\_

\_\_\_\_ Cell phone      # \_\_\_\_\_

\_\_\_\_ Text      # \_\_\_\_\_

\_\_\_\_ E-mail      \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**Authorization for Release / Exchange  
Of Medical Information**

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize Snake River Counseling to exchange and/or release my protected health Information (PHI) with the agency or person listed below:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phn: \_\_\_\_\_ Fax: \_\_\_\_\_

Type of PHI to be disclosed to or by Snake River Counseling:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am aware that this authorization is voluntary and if the person or entity authorized by this document to receive my PHI is not a health plan or health-care provider, then the disclosed PHI information may no longer be protected from further disclosure by state and federal law.

This authorization will expire on \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

I understand that signing this form will not affect my healthcare and I may revoke this authorization at any time by notifying Snake River Counseling. Furthermore, I understand that my revocation of this form will not affect any actions taken by Snake River Counseling prior to the time it received my revocation. Also, I may see a copy of the information described on this form if I request it and may get a copy of this form after signing it.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If not signed by patient indicate relationship: \_\_\_\_\_