1075 S. Utah Ave., Suite 352 ● Idaho Falls, ID 83402 ● **208.325.5770**

Counseling Registration

Name: ____ Male ___ Female __ Non-binary __

Mailing Address: Marital Status? ______ _______

Spouse's Name: _________________

Age: ________ Date of Birth: ____________________ Birthplace: ___________________________________

Phone number: ____________________________ Email Address: ____________________________________

Is it okay to leave voice messages or texts for Appointment reminders? Yes ______ No ______

Referral Source: _______________________________

Current Concerns:

Current Medications :

Employer/School Information:
Occupation: ____
Employer: ____

Highest Grade Completed: ___________________________
Current School (if a student): ___________________________

Primary Care Physician: _______________________________

Will Dr. Craig need to communicate with a physician or family member? Yes_______ No_______

Do you request insurance submission? Yes______ No______

Your Signature authorizing insurance submission: _______________________ Date _____________

If yes:
Insurance Provider: ____

Policy or Member ID #: _____________________________________ Copy of card taken? Yes _____ No _____

INFORMED CONSENT FOR TREATMENT

This form will provide information about our services and about your rights and responsibilities as a client. Please be sure to discuss any questions with the provider. Your signature at the bottom indicates that you understand the information and freely consent to participate in treatment.

I understand that treatment may involve discussing relationship, psychological, and/or emotional issues that may at times be distressing. I also understand that this process is intended to help me personally and/or with my relationships. I am aware of alternative treatment options and other treatment providers available. All of my questions about treatment options have been answered satisfactorily. If I have further questions, I understand that the provider will either answer them or find answers for me. I understand that I may leave therapy at any time, although I understand that this is best accomplished in consultation with my therapist. I also understand that my therapist reserves the right to discontinue treatment, if clinical judgment calls for such action (e.g. based on client status/progress, changes in client needs, provider practice issues, etc.).

CONFIDENTIALITY & CLIENT RECORDS:
The information obtained in this evaluation is confidential and will not be released to any person or organization without your written consent. The only exceptions to this policy are rare situations in which I am required by law to release information without your permission. These are 1) if there is evidence of physical and/or sexual abuse of children, or abuse to the elderly; 2) if it is judged that you are in danger of harming yourself or another individual; or 3) if your records or the provider's testimony are sought by subpoena or court order. I will attempt to notify you before any action is taken and would limit disclosure of confidential information to the minimum required to comply with the law.

FEE AND PAYMENT POLICY:
The standard fee for counseling is $175 for a 55-minute session. The standard fee for a 40-minute session is $130. ***Payment for co-pays, deductibles, etc. is the client's responsibility, and will be due in full at the time of service.*** Submission to private insurance companies may be done, upon request. Pre-authorization, if required, is the responsibility of the client. Any unpaid balance (e.g. due to insurance denial or non-payment) is the client's responsibility.

MISSED APPOINTMENTS:
For the courtesy of other clients who are waiting for appointment times, Cancellations must be made at least 24 hours before the scheduled appointment. Late cancellations (less than 24 hours) and "No-Shows" will be assessed a $50 fee to be paid prior to scheduling their next appointment. Two late cancellations or "No-Shows" will result in the client no longer being eligible for services at Craig Counseling.

AGREEMENT:
I have read the above material, and I fully understand my rights and obligations as a client. I freely agree to treatment, with the specified conditions.

Name of Client Date

Signature Date
(Client)

Acknowledgement of Notice of Privacy Practices: HIPAA

The Notice of Privacy Practices tells you how the provider may use and share your health records:

- to treat you and to bill for the services,
- to run the business, and
- to comply with laws related to health records.

All the ways that the provider may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of who the provider has given your health records to.
3. You have the right to ask to correct a mistake in your health records.
4. You have the right to ask that the provider not use or share your health records.
5. You have the right to ask the provider to change the way he contacts you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have had the opportunity to receive a copy of the Notice of Privacy Practices.

____

Name of Client

____

Signature (Client) Date

Consent

I **give, Craig Counseling, my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.**

I have been informed that I may review Craig Counseling's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Craig Counseling has the right to change privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

____

Name of Client

____

Signature (Client) Date

CRAIG
COUNSELING

Consent to Release Medical Information

(complete this page only if you want information be shared)

Name of Client: ________________________ **Date of Birth: __________________**

Information to Be Released: **□ Communication with Provider/Family Member/Other Person**
□ Treatment Records

Designated office from which information is being requested:

Name:	**Craig Counseling**
Address:	**1075 S. Utah Ave., Suite 352**
	Idaho Falls, ID 83402
Phone:	**(208) 325-5770** **(Fax #: (208) 510-0022)**

Physician, Family member, or Other Designated Person authorized to communicate and/or receive information specified above:

Name: _____________________________________

Address: ____

Phone: ______________________________ Fax: ____________________________

Purpose of Disclosure: ____

Statement of Consent:

The undersigned does hereby authorize and consent to the disclosure of any and all information, records, documents, reports, clinical abstracts, histories and charts, of every kind and description, relating to the condition, care, confinement and treatment of the above-named patient, by the above-named individual or entity or their representative, to the above-named physician or other designated person(s), and does consent to the inspection and duplication of the indicated records by the same. Treatment is not conditional upon signing this release, and the client has the right to revoke this release at any time.

The undersigned further agrees to waive any and all privileges granted under the provision of law which may either directly or indirectly pertain to this disclosure as hereby authorized. This release will remain valid for 6 months from the date of signature.

Signature____

Date ____

Office use only:
Reason unable to obtain signature: ____
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