REGISTRATION
(Please Print)


Date_____ Primary Phone Number_____ Secondary Phone Number_____

## PATIENT INFORMATION

Name _____ SS/HIC/Patient ID#_____

Address _____ Email_____

City_____ State_____Zip _____``

Sex M____ F ____ Age ____ Birth date _____ Marital Status _____

Under 18 Parent/Legal Guardian Name_____ Preferred Language_____

Address _____

Patient/Employer/School_____ Employer/School Phone_____

## PRIMARY INSURANCE

Insurance Company _____ Phone _____

Policy #_____ Plan Name _____ Group #_____

Insured Name_____ Insured DOB_____

Insured Address _____ Insured SS# _____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Employer_____ Address_____

Client's relationship to insured_____

## ADDITIONAL INSURANCE

Is client covered by additional insurance? Yes _____ No _____

Subscriber Name_____ Birth date _____ Relation to client _____

Address _____ Phone _____

City _____ State _____Zip _____

Insurance Company _____ SS # _____

Policy #_____ Group # _____

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with Insurance company (ies) listed above and assign directly to **All About Life Counseling Services** all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance Submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) for the purpose of obtaining payment for services and determining insurance benefits.

_____ _____ _____

Client Signature (Parent of client if under 14) Date Client Signature (14 or older)


Client Name _____

Name of Primary Physician _____

May we contact your Primary Physician regarding your treatment? YES NO

Name & Address of Hospital you prefer _____

_____

**EMERGENCY INFORMATION**

Emergency Contact Name _____

Phone # _____ How Related _____

**ACCOUNT INFORMATION**

Name of person responsible for Account _____

Address _____

Home Phone # _____ Cell Phone # _____

Do you have a secondary Insurance? YES NO

If Yes, Insurance Co. Name _____

Insurance Co. Phone # _____ Policy # _____

Insured Name _____ Phone # _____

**REFERRAL INFORMATION**

Referred by: Agency Name or referral source _____

CLIENT MEDICAL INFORMATION

Client Name_____ Date of Birth _____Age _____

Allergies/ Reactions to medication (past or present) _____

History of present physical symptoms or illness_____

_____

Medications (Please list all medications you are currently taking)_____

_____

History of past physically illnesses (include accidents and surgeries) _____

_____

Past Medications _____

Date of Last Physical Examination_____ Family Physician _____ Phone number _____

Address_____

Health Behavior: Do you smoke?_____ How many per day?_____ If you quit, how long ago?_____

Do you exercise? _____ How many times per week? _____How many hours a day?_____ Are you currently dieting?_____

Are you sexually active?_____ How many partners have you had in the last 5 years?_____

| Have you or any blood relative ever had: | | | Who? |
|---|---|---|---|
| Cancer | yes | no | _____ |
| Tuberculosis | yes | no | _____ |
| Diabetes | yes | no | _____ |
| Heart Problems | yes | no | _____ |
| High Blood Pressure | yes | no | _____ |
| Stroke | yes | no | _____ |
| Epilepsy | yes | no | _____ |
| Suicide attempts | yes | no | _____ |
| Mental Disorder | yes | no | _____ |
| Environmental Allergies | yes | no | _____ |

Do you have any physical or developmental disabilities (describe)_____

Have you ever been physically or sexually abused? _____ By who and when?_____

History of past or current pregnancies _____

_____ _____

Client Signature (Parent/ Legal Guardian if client is under 14) Date

Client Name_____ Application for Services

I am applying for services at All About Life. I give consent to All About Life to provide treatment to members of my family/or myself. If I am unable to keep appointments, I agree to notify my counselor at least 24 hours in advance. I understand that if I fail to provide 24 hour notice of cancelling an appointment and /or miss 3 appointments in a 120 day period, my treatment will be discontinued and I will be referred to another agency in order to continue services. If I miss my appointment without prior notice, I may be billed a "no show" fee of $25. I understand that this fee is not covered by my insurance and I will bear the financial responsibility

I understand the information gathered here is confidential. Release of such information can only be made by my written permission or by legal/clinical requirement or for the purpose of collection of delinquent accounts. I agree to comply with the terms of the application written above and I certify this agreement with my signature.

Client (Parent/Legal Guardian if child) _____ Witness _____ Date _____

For Clients with MEDICAID

All About Life is a private, for profit counseling agency staffed by qualified mental health professionals. Our operating expenses are supported by client fees, third party payers and Medicaid. In order for your services to be covered, you must bring in your Medicaid Card prior to being seen your first visit. We must make a copy of this card for our files. Failure to do so may result in a cancelled appointment. Any information or changes in your Medicaid coverage will be required from you immediately. Any other medical insurance coverage will be utilized before this public assistance.

In signing this document, I authorize All About Life to bill Medicaid and I acknowledge that I have received a written copy and an explanation of All About Life's client rights policy and grievance procedure.

_____ _____

Client Signature (req. if 14 and over) Signature of (Parent / Legal Guardian) Date

_____

Client Name (please print)

Payment Agreement/Authorization to Release Information to Third Party Payer(s)

I agree to pay the standard fee as follows:

Diagnostic Interview –Therapist-$140/Psychologist-$165.
Individual Counseling – Therapist-$110/Psychologist-$125
Couples / Family – Therapist-$120/Psychologist-$130
Group Therapy - $65
Psychological Testing - $175 per hour

I understand that the standard fee schedule listing all services is posted in the waiting room. I understand that I am responsible for any and all fees not covered by my insurance. All About Life will bill my insurance as a courtesy.

I agree to pay my fees at the time of the service rendered, unless other payment arrangements have been made. The insurance co-payment and/ or co-insurance will be due at the time of service.

If an organization or an insurance company will be paying all or a portion of the cost of the service that is provided to me, I give my permission to provide the "third party payers" with such information as may be required for All About Life to receive payment. I understand that I may revoke this consent at any time, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it. This release will remain in effect until 90 days after termination of service.

At the end of my services, I understand that the balance on my account is my responsibility. At that time, I will pay the balance in full or make new payment arrangements. If my account goes over 120 days delinquent, a late fee may be assessed monthly. I will be responsible for any and all fees or charges incurred should my account be turned over to collections.

_____ _____ _____

Client (Parent / Legal Guardian) Witness Date

**Client Name**_____

## Orientation To Services

Welcome to All About Life. To ensure that your relationship with us is both successful and as stress free as possible, we would like to orient you to the services available. Our desire is to provide a quality Behavioral Health Program that is designed to meet your needs and that will support and maximize the quality of life of those served. We seek to achieve this through psychological assessment, individual, group and family therapy on an outpatient basis. The services we provide will be integrated and coordinated with other service agencies so that when ancillary support is needed it will be provided by referral and/or consultation.

Our criteria for admission is as follows: 1) Your treatment needs are within the scope of our services 2) you can function on an outpatient basis 3) you will be compliant with our policies and procedures as explained to you 4) you are an adult (minors must be represented by a custodial parent or guardian) 5) and that you know and can pay the fee charged and/or are willing to apply with your therapist for a reduced fee if necessary.

At your first session, you will be asked to fill out and sign the following forms: 1) Registration information 2) Copy of your current insurance card 3) Client medical information 4) An application for service 5) If under the age of 18 or over the age of 65 an authorization for your primary care physician to release and assessment of your last physical.

The office staff will advise you of our policy and procedures and your client rights which are displayed on the wall in the waiting room. You will also be given a handbook outlining these procedures. Any concerns regarding services provided here should first be directed to your therapist (as he or she is your primary care coordinator).

During your first session with your therapist, you will be asked to collaborate in filling out an intake report that will clarify your presenting problem, symptoms and events leading up to your application of services. All services will be completed in a timely manner incorporating teamwork on the part of the therapist and the client.

On or before the 3rd visit or within the first 30 days of treatment you will do an Individualized Service Plan. With the help of your therapist this plan will outline the goals and objectives you wish to achieve in therapy, a time frame for meeting these goals and a way to measure your success. At the end of your treatment, you will be asked to assist in filing a discharge agreement, summary of treatment, and a follow up plan to monitor your future progress for a specified length of time. Criteria for discharge are as follows: mutual agreement as identified that the goals have been met, upon client request, client is non compliant to treatment, client moves out of area, or client is deceased. This signed agreement will be kept in your file and we look forward to working with you.

_____ _____

Signature (Parent or Guardian if client is under 14) Date

_____ _____

Signature (Clients 14 or older) Date

Client Name _____

**Informed Consent for Treatment**

Each treatment I receive has risks and benefits associated with it. The risks and benefits are outlined below and have been explained to me. My signature indicates that I wish to receive treatment, and that I have had these benefits and risks explained to me as well as any others that may apply.

Diagnostic Assessment: Diagnostic assessment is an evaluation done to identify problems presented. It indicates information, received from the client in a variety of areas including stressors, health problems, medication, specific behaviors, hospitalizations, prior mental health treatment, etc.

Signature_____ Date _____

Counseling/Psychotherapy: I understand that therapy is a collaborative effort and that success or failure is a function of the efforts of both the therapist and myself. Specific benefits of an effective therapy for me are outlined in my Individual Service Plan. General benefits of therapy may include relief of symptoms, increased insight and confidence, and improvement in my daily functioning. I understand that verbal therapies may produce a temporary increase in stress due to focus on problem areas, and professional literature suggests that approximately 10% of therapy clients become more dysfunctional as a result of the stress of treatment.

Signature_____ Date_____

I understand that I have the right to refuse any and all treatment. However, my service provider may also decline to provide me a treatment if I refuse or cannot comply with the necessary requirements of that treatment. I understand that I have a right to withdraw my consent for any and all treatments. If I refuse or withdraw from a treatment, my service provider will make an effort to develop alternate approaches with me to get the services I need.

I consent to receive the services for me or for my child to receive the services for which I have signed and dated.

_____ _____ _____

Client Signature (req. if 14 and over) Parent or Legal Guardian Signature (req. if client under 14) Date

**********

I refuse consent for treatment services recommended for me or my child.

_____ _____

Client / Guardian Date

I hereby withdraw my consent for the services provided for me or my child.

_____ _____

Client/Guardian Date

# INFORMED CONSENT TO TELEHEALTH

Telehealth allows the therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____ Clinician: _____

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and my therapist may believe I would be better served by another form of psychotherapeutic services, such as in-person treatment.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to All About Life. My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Authorized Signature of Client Date

_____ _____

Parent or Guardian (if under 14 years old) Date

**TELEHEALTH CONSENT**
**CLIENT RESPONSIBILITIES**

Understanding that TeleHealth services inherently carry unique challenges, both technologically and in regards to privacy, we are asking at that clients take the following preventative steps:

- Make sure that the needed software/applications are downloaded and registered for prior to your first TeleHealth counseling session.

- Avoid delays from technical “hic-ups” by signing in to your session meeting at least 5 mins prior to its start time.

- Make sure you are in the state of Pennsylvania when you are scheduled for your TeleHealth session.

- In order to uphold the integrity of the counseling treatment, please make sure you are in a private and quite location at the time of your scheduled session.

- Please also make sure that any device you are using is charged.

By signing below, you acknowledge your part in making TeleHealth Services as successful and beneficial as possible.

_____ _____

Client Signature Date

_____ _____

Parent Signature (if client under 14 years old) Date

All About Life
COUNSELING SERVICES

4056 East State Street Hermitage, PA 16148
(724) 981- 5433
Fax # 724-981-5432

This form is an agreement between you, _____ and All About Life Counseling Services.
(Client Name)

In order to provide counseling services, we will be collecting what the law calls "protected health information" (PHI) about you. We will need to use this information in our office to provide you with the best type of treatment. We may also share this information with others to arrange payment for your counseling services, to assist others who are providing you services or to help us carry out certain business or government functions.

By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

**If you do not sign this form agreeing to our privacy practices, we cannot provide you with services.**
In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change our practices, you can get a new copy from the office.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for counseling, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you have requested.

After you have signed this consent, you have the right to revoke it by writing to our office. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we would not be able to reverse this use/sharing.

_____ _____ _____
Client Signature (req. if 14 and over) Date Office Witness

_____ _____
Parent or Legal Guardian Signature Date
(req. if client under 14)

# ALL ABOUT LIFE – HIPPA

## NOTICE TO CLIENTS REGARDING APPOINTMENTS

As a client of All About Life Counseling Services, you have provided your phone number(s) for the purpose of receiving reminder calls from our office.

- We provide a reminder call the day before your appointment.
- We will leave a message with the date and time of the appointment.
- Please provide 24 hour notice, if you are unable to make a scheduled appointment.
- We will also utilize your phone number to contact you to schedule an appointment you may have requested on our waiting list.
- We will also call to cancel an appointment when necessary.

Primary Phone number: _____

Secondary Phone number: _____

☐ Check if you **Do NOT** want our office to leave messages regarding your appointments.

Please provide the names and phone numbers of those individuals who may contact our office to schedule, confirm or cancel an appointment on your behalf.

| Name of HIPPA Approved Contact | Relationship to Client | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

_____ _____ _____

Client Name Date Client Signature

_____ _____

Parent or Legal Guardian Signature (req. if client under 14) Date

All About Life
COUNSELING SERVICES

4056 East State Street Hermitage, PA 16148
(724) 981- 5433

## AUTHORIZATION TO RELEASE INFORMATION

For the purpose of coordination of care and that purpose only, the undersigned hereby authorizes and requests **All About Life** to disclose information to and from:

| _____ | _____ | _____regarding: |
|---|---|---|
| Physician/Agency | (Location/Address) | (Telephone) |
| _____ | _____ | _____ |
| (Client's Name) | (Social Security #) | (Date of Birth) |

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drugabuse, HIV/AIDS test results or diagnoses.

**The information to be release includes: Please check all that apply**

| | | |
|---|---|---|
| ___ Discharge Summary | ___HIV/AIDS related information | _X_ Consultations |
| ___Psychiatric Evaluation | Specify_____ | ___Multi-Disciplinary Aftercare Plan |
| ___History & Physical | ___ Physician Progress Notes | ___Laboratory Data |
| ___Psychological Assess. | _X_ Treatment Plan | ___ X-Ray Reports |
| _X_ Intake Assessment | ___Behavior Report/Observation | __x_ Verbal Communication |
| ___Other(specify)_____ | ___Educational Information (IEP, Grades)with **All About Life** | |

In any event, this consent is subject to revocation at any time to the extent that action had been taken in reliance thereon. ***Unless otherwise revoked, this authorization will*** expire ***one year from the date of signature.***

| _____ | _____ | _____ | _____ | _____ |
|---|---|---|---|---|
| Date | Client Signature (req. if 14 or older) | Date | Parent/Legal Guardian Signature (Signature req. if client under 14) | Relationship |

| _____ | _____ |
|---|---|
| Date | Staff Member/Witness Signature (Print last name) |

**Notice to Recipient: Prohibition of Redisclosure**

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42, CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

---

**REVOCATION:** I hereby revoke the above consent and refuse any further information to be released

| _____ | _____ |
|---|---|
| Signature | Date |

All About Life
COUNSELING SERVICES

4056 East State Street Hermitage, PA 16148
(724) 981- 5433

## AUTHORIZATION TO RELEASE INFORMATION

For the purpose of coordination of care and that purpose only, the undersigned hereby authorizes and requests **All About Life** to disclose information to and from:

| _____ | _____ | _____regarding: |
|---|---|---|
| (Guardian) | (Location/Address) | (Telephone) |
| _____ | _____ | _____ |
| (Client's Name) | (Social Security #) | (Date of Birth) |

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses.

**The information to be release includes: Please check all that apply**

| | | |
|---|---|---|
| ___Discharge Summary | ___HIV/AIDS related information | ___Consultations |
| ___Psychiatric Evaluation | Specify_____ | ___Multi-Disciplinary Aftercare Plan |
| ___History & Physical | ___Physician Progress Notes | ___Laboratory Data |
| ___ Psychological Assess. | ___Treatment Plan | ___X-Ray Reports |
| ___Intake Assessment | ___Behavior Report/Observation | __x_ Verbal Communication |
| __ Other(specify)_____ | ___Educational Information (IEP, Grades) | with **All About Life** |

In any event, this consent is subject to revocation at any time to the extent that action had been taken in reliance thereon. ***Unless otherwise revoked, this authorization will*** expire ***one year from the date of signature.***

| _____ | _____ | _____ | _____ | _____ |
|---|---|---|---|---|
| Date | Client Signature (req. if 14 or older) | Date | Parent/Legal Guardian Signature (Signature req. if client under 14) | Relationship |

| _____ | _____ |
|---|---|
| Date | Staff Member/Witness Signature (Print last name) |

**Notice to Recipient: Prohibition of Redisclosure**

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42, CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

---

**REVOCATION:** I hereby revoke the above consent and refuse any further information to be released

| _____ | _____ |
|---|---|
| Signature | Date |

All About Life
COUNSELING SERVICES

4056 East State Street  Hermitage, PA 16148
(724) 981- 5433
Fax # 724-981-5432

**COUNSELING ATTENDANCE POLICY**

Therapy is a collaborative process that is dependent on the efforts of both the client and therapist. As such, All About Life has an attendance policy to ensure that clients regularly attend their scheduled appointments for an overall successful therapeutic process for all clients.

Recognizing that everyone's time is valuable and that appointment time is limited, we ask that you provide 24 hour notice if you are unable to keep your appointment. Our policy is to call clients 1 day prior to their appointment to remind them of their scheduled date and time. We perform these calls as a courtesy to our clients and to allow us the opportunity to rebook the time slot should the appointment not be necessary.

In the event that you miss an appointment, "no show", on 3 occasions within a 120 day period, we will need to terminate our services and refer you to another agency.

If you miss an appointment without prior notice, you may be billed a "no show" fee of $25. Please understand that this fee is not covered by your insurance and you will bear the financial responsibility.

**Please note that failing to provide 24 hour notice may also be considered a "No Show", at the therapist's discretion.**

I, _____have read the above Attendance Policy and understand that my cooperation and active participation directly relates to the success of my therapy program.

_____ _____

Patient Signature Date

_____ _____

Therapist Signature Da**te**

All About Life
COUNSELING SERVICES

4056 East State Street  Hermitage, PA 16148
(724) 981- 5433
Fax # 724-981-5432

**Notice of Important Updates:**

As everyone knows, the COVI-19 Pandemic has brought numerous and continuous changes to everyday routines and services. Please review the following information as it applies to your services/treatment at All About Life Counseling Services:

- If you are feeling unwell, please call into the office and request that your appointment be changed to a telehealth appointment or reschedule.

- Beginning October1, 2021 all telehealth appointments must be completed using Zoom. **Phone only appointments will no longer be offered.** Please make sure that you have a Zoom account set up in case your appointment would need to be switched to telehealth.

- Cost share waivers for telehealth appointments for most insurances have ended. Please be prepared to make your copay/deductible payments the day of your appointment.

Thank you for your patience and understanding during this time. If you have any questions or concerns, please feel free to call the office at 724-981-5433.

_____ _____

Client Signature (14 and older) Date

_____ _____

Parent/Guardian Date