
# New Client Registration Form

Client Name_____

Address_____

_____

*Contact Information:*

Home (_____)_____ Work (_____)_____

Cell (_____)_____ Email_____

Age/Birthdate_____

Sex **M** **F** Marital Status **S** **M** **D** **W**

Student/School_____

Employer_____

Occupation_____

In case of emergency notify_____

Emergency contact number_____

Referred by_____

*I certify the above information is correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Journeys Christian Counseling.*

_____ _____

Client/Guardian Signature Date

Please circle all of the following issues that currently concern you.

| | | |
|---|---|---|
| Stress | Nervousness | Anxiety |
| Fears | Chest Pains | Muscle Tension |
| Nervous Tics | Palpitations | Phobic Avoidance |
| Compulsions | Stomach Trouble | Chronic Pain |
| Binging | Vomiting | Purging |
| Depression | Sleep Problems | Loss of Interest |
| Withdrawal | Low Self Worth | Memory |
| Concentration | Guilt | Inferiority Feelings |
| Suicidal Thoughts | Suicidal Plans | Loneliness |
| Relationship Stress | Shame | Abuse |
| Flashbacks | Dissociation | Nightmares |
| Hurting Self | Risk-Taking Behavior | Drug/Alcohol Use |
| Anger | Aggressive Behavior | Temper Outbursts |
| Jealous Feelings | Loss of Control | Suspicious of Others |
| Marriage Difficulties | Parenting Difficulties | Gender Issues |
| Sexual Problems | Learning Disability | Finances |
| Career Choices | Work | Legal Matters |
| Hallucinations | Hearing Things | Delusions |
| Unusual Experiences | Other:_____ | Other:_____ |

Briefly describe what brought you to counseling?

_____
_____
_____

What do you hope will be different after the counseling process?

_____
_____
_____

# Journeys Christian Counseling

## Client Information and Consent to Treatment

Thank you for choosing Journeys Christian Counseling for your counseling needs. We are committed to giving you the best care possible. To acquaint you further with the procedures and policies of our office, we are providing the following information.

**Appointments:** If you need to cancel an appointment, a minimum of 24 hours notice is required; otherwise you are subject to full charge for the missed appointment. In the evenings and on weekends, you may leave a message on our voicemail, which will accurately report the date and time you called. We will do our best to be punctual for your appointment unless we have an emergency situation. We ask that you be punctual as well. If you are late, for any reason, you will receive the remainder of your scheduled time. This is necessary so we can see clients at their scheduled times.

**Emergencies:** In case of an after-hours emergency, go the nearest emergency room. To leave a message for your counselor, call his/her regular daytime phone number.

**Financial Responsibility**: You are fully responsible for all services rendered. Full payment is expected at the time of service, unless other contractual arrangements apply. Please make all checks payable to Journeys Christian Counseling. Another payment option is Credit Card or Health Savings Cards. There will be a $25 fee for payments returned as non-sufficient or non-payable. Billing processes may include a monthly statement, phone call, or correspondence regarding the patient due portion of the account balance. Statements, phone calls, and correspondence will be addressed to the client/guarantor address or phone numbers listed on the Client Registration Form. If any of these business office procedures present a problem for you and your treatment, please discuss your concern with your counselor.

**Confidentiality**: Your client records are the property of Journeys Christian Counseling and shall be treated as confidential. To comply with state and federal laws regarding patient confidentiality, your records will not be released without a properly executed written consent. Everything about your care will be held in strictest of confidence (with the exception of those situations which we are required by law to report; such as, suspected or reported child abuse, etc.) If you choose to have your counselor keep a third party informed of your progress in counseling, it will be necessary to complete a “Release of Information” form that will be kept on file.

****Please sign below to indicate that you understand the above notifications and that you are consenting to receive treatment from Journeys Christian Counseling.**

_____ _____

Client/Guardian Signature Date

# Journeys Christian Counseling

## Client Rights

You have the following rights under state and federal law:

**Copy of Record:** You are entitled to inspect the medical record our office has generated about you. We may charge you a reasonable fee for copying and mailing your record.

**Release of Records**: You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or other person you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

**Restriction on Records:** You may ask us not to use or disclose part of the medical information. This request must be in writing. Journeys Christian Counseling is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. This request should be given to your counselor.

**Contacting You**: You may request that we send information to another address or by alternative means

**Amending Record:** If you believe that something in your record is incorrect or incomplete, you may request we amend it.

**Accounting for Disclosures:** You may request an accounting of any disclosures we have made related to your medical information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years please submit your request in writing to Journeys Christian Counseling. We will notify you of the cost involved in preparing this list.

**Questions and Complaints:** If you have any questions, or would like to request a copy of this policy or have any complaints, please state such in writing to Journeys Christian Counseling, 2011 Corona Rd, Ste. 315, Columbia, MO 65203. You may communicate grievances to the Secretary of Health and Human Services if you believe our office has violated your client rights. We will not retaliate against you for filing a complaint.

**Changes in Policy:** Journeys Christian Counseling reserves the right to change its Privacy Policy based on the needs of the clinic and changes in state and federal law.

*****Please sign below to indicate you understand and agree to the above policy concerning Client Rights.**

_____ _____

Client/Guardian Signature Date

# Journeys Christian Counseling

## Notice of Privacy Practice (HIPAA)

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. We respect client confidentiality and only release medical information about you in accordance with state and federal law. This notice describes our policies related to use of records of your care generated by this office.

**Use and Disclosure of Protected Health Information**

In order to effectively provide you care, there are times when we will need to share your medical information with others beyond our clinic. This includes for:

Treatment: We may use or disclose medical information about you to provide, coordinate, or manage your care or any related services.

Payment: Information will be used to obtain payment for the treatment and services provided. This will include contacting your managed health insurance company for prior approval of planned treatment, insurance verification, or for billing purposes.

Healthcare Operations: We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and staff training.

**Information Disclosed Without Your Consent**

Under state and federal law, information about you may be disclosed without your consent in the following circumstances:

Criminal Activities or Danger to Self or Others: Sufficient information may be shared to address the immediate emergency self-harm or the imminent harm of others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

Follow-Up Appointment/Care: We may be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law: This would include situations where we have a court-ordered subpoena, or are mandated to provide public health information, such as communicable diseases or suspected abuse and/or neglect such as child abuse or elder abuse.

*****By signing below you acknowledge you understand and agree to Journeys Christian Counseling Notice of Privacy Policies.**

_____ _____

Client/Guardian Signature Date