CHRISTENSEN AND SONS, INC.

REGISTRATION

(Please Print)

Client's Full Name: _____ Date of Birth: ___/___/_____

Home Address: _____ City: _____ State: ___Zip: _____

Home Phone: (___)_____Cell Phone: (____)_____ Sex:____ Age:_____

Email: _____ @ _____ Student: Yes__ No__ Grade _____

When contacting me:

☐ Do not contact by phone call
☐ Do not contact by text messages
☐ Do not contact by email
☐ Do not mention agency name

Family Physician: _____ Phone: (___) _____ Referred by: _____

Emergency Contact: _____Phone: (___) _____ Relationship: _____

Referral:

☐ Church/Parish
☐ Family member referral
☐ Google Search
☐ Insurance Companies
☐ Another Counselor
☐ Previous client
☐ Psychology Today
☐ Returning client
☐ Theravive

Religion:

☐ Protestant
☐ Catholic
☐ Jewish
☐ Mormon
☐ Orthodox
☐ Muslim
☐ Hindu
☐ Buddhist
☐ Atheist/Agnostic
☐ Other _____

Gender:

☐ Male
☐ Female
☐ Transgender M-F
☐ Transgender F-M
☐ Other _____

Race:

☐ Black/African American
☐ Asian
☐ Hispanic/Latino
☐ Multiracial
☐ American Indian/Alaska Native
☐ Hawaiian Native/Pacific Islander
☐ White/Caucasian

Relationship Status:

☐ Married
☐ Single
☐ Widowed
☐ Divorced
☐ Separated
☐ Common Law
☐ Living Together
☐ Partners
☐ Engaged
☐ _____

Employment Status:

☐ Employed
☐ Unemployed
☐ Student Full-time
☐ Retired
☐ Disabled
☐ Student Part-time

Employer: _____ Occupation: _____

School/College/University: _____ Area of Study: _____

Spouse's or Parent/Guardian Name: _____DOB: ____/____/_____

Home Phone: (____)_____ Cell Phone: (____)_____ Sex:_____ Age:_____

Same Home Address: ☐Yes ☐No Spouse's/Parent/Guardian address: _____

Email: _____@_____ May we contact you by email? ☐Yes ☐No

Client/Insured Signature _____ Date _____

Spouse/Parent Signature _____ Date _____

CHRISTENSEN AND SONS, INC.

Insurance, Billing, Payment, and Fees Information

INSURED/RESPONSIBLE PARTY INFORMATION

Please complete applicable portions of this section regardless of insurance coverage.

Full Name of Insured: _____Sex: ____ Relationship to Insured: _____

Occupation: _____ Insured's DoB ____/____/_____

Home Address: _____ City/State/Zip: _____

Employer name:_____ Phone: (_____)_____

Employer Address: _____ City/State/Zip: _____

Insured's SS# _____ Driver's License. #_____ State:_____

Insured Primary Ins. Co.: _____ ID#_____ Grp# _____

Telephone # of Insurance Customer Service: (_____)_____

Secondary Ins: __N __Y Insurance Company _____ Policy #_____

Job Related Injury / Workman's Comp: __N __ Y: Company: _____ Insured's DOB ___/___/___

Telephone # of Insurance Customer Service: (_____)_____

OFFICE BILLING AND INSURANCE POLICY

- I understand I am to make checks payable to Christensen And Sons, Inc.
- I authorize the use of this form on all my insurance submissions.
- I authorize the release of information to my insurance company(s).
- I authorize direct payment to my service provider.
- I hereby permit a copy of this to be used in place of an original.
- I understand that it is my responsibility to pay any deductible, co-insurance amount, or any other balance not paid by my insurance, for services provided.
- I understand a payment for any deductible, co-insurance amount is expected no later than 30 days after receipt of billing information from this office.
- I understand that it is my responsibility to pay any co-pay the day and time services are provided.
- I understand I may request a payment plan or apply for a Grant to assist with the payment of my fees.
- I understand that there will be a service charge, not less than $35.00, on all returned checks.
- I understand that there is a 24-hour cancellation policy which requires that I cancel my appointment **by telephone** (please do not email) 24 hours in advance of my schedule appointment. I agree to pay the cancellation fee.
- I understand I am responsible for all collection and or attorney fees.
- I agree that all information provided is correct

Name: _____ Signature: _____Date:____/____/___

Name: _____ Signature: _____Date:____/____/___

CHRISTENSEN AND SONS, INC.

Authorization Form for Release of Confidential Health Information

I, _____, hereby authorize Christensen and Sons, Inc to release
(Name of Patient or Authorized Agent)

to/or secure from _____
(Name of Health Care Facility, Physician, Agency etc.) (Street Address, City, State, Zip)

the following information contained in the patient record of _____ born: _____
(Patient's Name) (DOB)

To be disclosed, the following items must specifically be checked:

☐ Account Information
☐ Treatment Summary
☐ Office Psychotherapy Notes
☐ Verbal Discussion of Case
☐ Psychological Testing Report
☐ Other (specify): _____

The purpose(s) of the authorization is (are):

☐ At the request of the individual
☐ Coordination of Mental Health Treatment
☐ Payment of Account
☐ Other (specify):_____

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the practice of my desire to do so.

I also understand that I will not be able to revoke this authorization in cases where the therapist has already relied on it to use or disclose my health information. Written revocation must be sent to the practice. Absent such written revocation, this Authorization for Release of Confidential Health

Information will terminate on _____
(Date)

_____ Date:____/____/____
(*Signature of Client)*

_____ _____
(Signature of Witness) *(Signature of Parent or Guardian)*

**Client signature is required in addition to the parent or guardian signature for clients ages 12-17.

CHRISTENSEN AND SONS, INC.

Notification to Patient of Desirability of Conferring with Primary Care Physician

It is desirable that you confer with your primary care physician, if you have one. If you have a primary physician, I will notify him or her that you are seeking or receiving mental health treatment unless you waive such notification.

Please indicate your wishes:

- ❏ My primary physician is _____

  Address: _____

- ❏ I agree to your notifying my primary care physician that I am seeking or receiving mental health services. I am signing this Authorization to Release Information permitting you to communicate with my said physician.

- ❏ I WAIVE NOTIFICATION of my primary care physician that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.

- ❏ I do not have a primary care physician and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a primary care physician that I am seeking or receiving mental health services.

_____ _____
Signature Date

_____ _____
Parent or guardian of minor patient or ward Date

Notification to Primary Physician of Patient Receiving Mental Health Services

This is to notify you that _____ is receiving mental health services from Christensen and Sons, LLC. The patient has signed an Authorization for Release of Information, a copy of which I am enclosing for your records. We look forward to the opportunity to confer with you about this patient as the occasion or need arises.

Erik Christensen, LCSW
773 758-3364

Lloyd Christensen, MSW, LSW
773 758-9242

Brandon Christensen MSW, PEL
773 758-9243

CHRISTENSEN AND SONS, INC.

PRE-AUTHORIZED HEALTH CARE CREDIT CARD PAYMENT FORM

I authorize the practice of Christensen and Sons, Inc to keep my signature on file and charge my credit card account for:

- ❏ Charges for appointments attended (fees for services rendered)
- ❏ Charges for missed appointments (including those not canceled within 24 hours as well as **no-show**(s)
- ❏ Balances of charges not paid to Christensen and Sons, LLC within 90 days

I understand that I may revoke this agreement at any time by providing a request in writing.

Client Name: _____

Cardholder's Name: _____
As it appears on the card

Cardholder's Address:_____*City*_____ *State* _____*Zip* _____

Credit Card (circle one): **Visa** **MasterCard** **Discover**

Account Number:_____

V-Code Number: _____ *(Three digits on back of card)* Expiration Date: _____

Signature: _____ Today's date: _____

E-mail Address: _____

Note: Email is not a secure form of communication and confidentiality cannot be guaranteed. By listing your email address here, you are giving consent of this communication.

Christensen and Sons, Inc agrees to charge only for reasons stated above and agreed upon rates.

Revised 11/2017

CHRISTENSEN AND SONS, INC.

Limits on Client Confidentiality

I am required to disclose confidential information if any of the following conditions exist.

1. You are a danger to yourself or others

2. You seek treatment to avoid detection or apprehension or enable to commit a crime.

3. Your therapist was appointed by the courts to evaluate you.

4. Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.

5. Your contact is for the purpose of establishing your competence.

6. The contact is one in which your psychotherapist must file a report to a public employer or as to information required to be recorded in a public office, if such report or record is open to public inspection.

7. You are under the age of 16 years and are a victim of a crime.

8. You are a minor and your psychotherapist reasonably believes you are the victim of child abuse.

9. You are a person over the age of 65 and your psychotherapist believes you are the victim of physical abuse. Your therapist may disclose information if you are the victim of emotional abuse.

10. You die, and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting as interest in property.

11. You file suit against your therapist for breach of duty or your therapist files suit against you.

12. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.

13. You waive your rights to privilege or give consent to limited disclosure by your therapist.

14. Your insurance company paying for services has the right to review all records.

If you have any questions about these limitations, please discuss them with me.

Please sign to verify that you understand the "Limits on Client Confidentiality" and you received a copy.

Signature: _____ Date: _____

CHRISTENSEN AND SONS, INC.

Hours and Cancellations: Psychotherapy sessions are typically 50 minutes long. Groups run about 90 minutes. If it becomes impossible for you to keep an appointment, it is important that you call to inform you therapist/counselor of your cancellation. Please do not send an email. Due to the policy of reserved appointment times, an appointment that you cannot keep must be cancelled no less than 24 hours before the appointment time. Appointments that have not been properly cancelled will be charged a cancelation fee of $50.00. Insurance companies, probation departments and employee assistance programs will not pay for missed sessions, so these will be your sole responsibility. It is not our agency established policy to call to remind clients of appointments. Payment for missed sessions is expected at the next scheduled appointment time.

Phone Calls: Our general policy is to leave only a name and phone number when phone calls are returned. Please indicate your consent to leave treatment information: appointment changes, account information, etc.

- ❏ I authorize a member of Christensen and Sons Inc, to leave information on my answering machine or voicemail
- ❏ I DO NOT authorize staff of Christensen and Sons Inc, to leave information on my answering machine or voicemail

INITIAL_____

I can be contacted by phone at: _____ or by mail at _____.

Emergencies: In the event of an emergency, you may contact me by phone. However, I will not usually accept calls if in session. If I am not available in case of emergency, please call your local crisis line, contact your primary care physician, your local health department, or proceed to your local emergency room. Call 911 in immediate matters of personal safety.

Confidentiality: We are committed to making this a safe place for you to get help. To that end, we adhere to all legal protections of your confidentiality. Limitations include staff consultation, life-threatening behavior, child abuse, elder abuse and judge's orders to release information.

Good communication between you and your counselor is vital to our ability to serve you well.

Please tell us about problems and questions that might arise.

If you don't understand an answer or if new problems arise, let us know.

We want to provide you with the best possible care, and we need your cooperation to succeed.

Please contact us if you have a concern.

All items have been fully explained to me; I understand them and take full responsibility for their contents. Signature: _____ Today's date: _____

CHRISTENSEN AND SONS, INC.

CLIENT'S Copy Date received _____

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CHRISTENSEN AND SONS, INC.

CLIENT'S Copy

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4. Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.

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7. You are under the age of 16 years and are a victim of a crime.

8. You are a minor and your psychotherapist reasonably believes you are the victim of child abuse.

9. You are a person over the age of 65 and your psychotherapist believes you are the victim of physical abuse. Your therapist may disclose information if you are the victim of emotional abuse.

10. You die, and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting as interest in property.

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12. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.

13. You waive your rights to privilege or give consent to limited disclosure by your therapist.

14. Your insurance company paying for services has the right to review all records.

If you have any questions about these limitations, please discuss them with me.

Complaints

If you are concerned that your counselor has violated your privacy rights, or you disagree with a decision your counselor made to in regards to your records, you may contact Mr. Erik Christensen CEO of Christensen And Sons, Inc at 773-758-3364 or christensenandsons@comcast.net.
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.