



New Client Enrollment Form

33 South State Street, Dover DE 19901 Phone: 302-530-4452
922A Washington Ave., Chestertown, MD 21620 Phone: 443- 571-8750

Fax: (570) 300-1648

Email: Info@aspirelifecenterllc.com

Date: _____

Client Name _____ D.O.B _____

Gender: (Please select): Male Female Other

Address: _____
City State Zip Code

Email Address: _____ Is it ok to email you? Y N

Phone: (_____) _____ Is it ok to leave a message for you at this number? Y N

Cell:(_____) _____ Is it ok to leave a message for you at this number? Y N

Emergency Contact Name: _____

Phone Number: (Please provide the best number) (_____) _____

Relationship to Patient: _____

Current Employer: _____

Current Occupational Status: _____

Primary Care Provider Name: _____

Address: _____
City State Zip Code

Phone Number (_____) _____

Insurance Information (Please answer all questions.)

Name of Insured: _____ D.O.B (Insured): _____

Name of Insurance Company: _____

Relationship to Patient: _____

Insurance ID# _____ Group# _____

Other insurance Coverage? Ins. Name: _____

Name of Insured: _____ D.O.B (Insured): _____

Insurance ID# _____ Group# _____



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Please list any current medications.

1.
2.
3.
4.
5.

Do you have any medical conditions? Y N Unknown

If yes, please provide a brief description.

Behavior Checklist: Select any behaviors that apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Sadness or crying | <input type="checkbox"/> Overeating | <input type="checkbox"/> Using drugs or alcohol |
| <input type="checkbox"/> Anger or temper outbursts | <input type="checkbox"/> Working too much | <input type="checkbox"/> Thoughts of self-harm |
| <input type="checkbox"/> Avoiding people or activities | <input type="checkbox"/> Impulsive actions | <input type="checkbox"/> Feeling withdrawn |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Loss of control | <input type="checkbox"/> Procrastinating |

Feeling Checklist: Select any feelings that apply to you:

- | | | | | |
|---------------------------------|----------------------------------|---------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Angry | <input type="checkbox"/> Sad | <input type="checkbox"/> Happy | <input type="checkbox"/> Tired | <input type="checkbox"/> Worried |
| <input type="checkbox"/> Lonely | <input type="checkbox"/> Excited | <input type="checkbox"/> Guilty | <input type="checkbox"/> Afraid | <input type="checkbox"/> Confused |

Physical Checklist: Select anything physically that applies to you:

- | | | | | |
|------------------------------------|-------------------------------------|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Tremors | <input type="checkbox"/> Numbness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Rapid heartbeat |

Please share any other concerns or important information: _____



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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Fax: (570) 300-1648

Email: Info@aspirelifecenterllc.com

Client Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above from / to: Fax: 1-570-300-1648

_____ **Aspire Life Center, LLC**
922 A Washington Ave
Chestertown, MD 21620
Office: 1(443) 571 - 8750

_____ **Aspire Life Center, LLC**
33 South State
Dover, DE 19901
Office: 1(302) 530 - 4452

This request and authorization apply to: **(Please select a response below)**

_____ **Healthcare information relating to the following treatment, condition, or dates:**

_____ **All healthcare information**

_____ **Other:**

Definition: Sexually Transmitted Disease (STD), as defined by law (RCW 70.24 et seq.), includes conditions such as herpes, HPV, genital warts, Chlamydia, syphilis, HIV/AIDS, gonorrhea, and other related infections.

Please select a response below:

_____ Yes _____ No I authorize the release of my **STD and HIV/AIDS test results** (positive or negative) to the person(s) listed above. I understand that they cannot share these results without my written permission.

_____ Yes _____ No I authorize the release of any **records regarding drug, alcohol, or mental health treatment** to the person(s) listed above, according to Section 42 CFR and HIPAA.

Print Name: _____

Client /or Guardian Signature: _____ Date Signed: _____

THIS AUTHORIZATION WILL BE CONSIDERED ASPIRE LIFE CENTER UNLESS REVOKED IN WRITING.



Client Rights and Responsibilities

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Client Rights

As a patient at Aspire Life Center, you have the right to:

1. Receive care in a safe, respectful, and compassionate environment.
2. Have your personal and health information kept private and confidential.
3. Understand your treatment options, procedures, and any related costs.
4. Participate in decisions regarding your care and treatment plan.
5. Refuse treatment, while being informed of potential consequences.
6. Ask questions and receive clear, understandable answers.
7. Express concerns or complaints without fear of retaliation.
8. Access your medical and counseling records in accordance with the law.

Client Responsibilities

As a patient at Aspire Life Center, you are expected to:

1. Provide accurate and complete information about your health and history.
2. Follow the treatment plan and instructions agreed upon with your care provider.
3. Treat staff, other patients, and property with respect.
4. Attend appointments on time and notify the center promptly if you cannot attend.
5. Ask questions if you do not understand any part of your care.
6. Follow the policies and procedures of Aspire Life Center.
7. Provide payment for services or accurate insurance information in a timely manner.

I have read and understand the above stated rights and responsibilities and agree to abide by these rights and responsibilities.

Print Name: _____

Client /or Guardian Signature: _____

Date: _____



Office Policies and Procedures

33 South State Street, Dover DE 19901

Phone: 302-530-4452

922A Washington Ave., Chestertown, MD 21620

Phone: 443- 571-8750

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Welcome to Aspire Life Center!

Our goal is to provide high-quality care in a safe, respectful, and supportive environment.

Voluntary Treatment

All evaluations, therapy, and medication management are voluntary and provided with your consent (or parent/guardian consent if under 18).

Provider Discretion

Your provider uses clinical judgment to determine appropriate treatments. They are not obligated to start or continue any treatment they do not deem suitable.

Appointments

- By appointment only.
- Missed appointments or less than 24-hour notice may incur a **\$50 fee**.
- Frequent missed appointments may lead to discharge from care.

Confidentiality

- Information shared in sessions is confidential, except as required by law (e.g., risk of harm, abuse, or court order).
- Records may be shared with your consent for coordination of care or insurance purposes.

Payment

- Fees, co-pays, or coinsurance are due at the time of service.
- Unpaid balances may be sent to collections with additional fees.

Phone & Urgent Services

- Routine calls: use office numbers; they may be returned on the next business day.
- After-hours calls: leave message; urgent matters call 911 or go to the ER.
- Crisis resources:

○ Rockford Center:
(302) 996-5480

○ Christiana Care
Psych Crisis:
(302) 428-2118

Meadow Wood Hospital:
(302) 328-3330



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Paperwork & Legal Limitations

- Paperwork: \$25–\$75 fee.
- Disability, custody, or court-related forms are completed at the discretion of the provider.

Treatment of Minors

- Patients under 18 must have a parent/guardian present for consent.

Medications Management

- Medication management is a referred service.

Discharge

- Discharge ends care, appointments, and medication refills.
- May occur due to missed appointments, noncompliance, or abusive behavior.
- You will be notified in writing and may receive a 30-day prescription at provider discretion.

By signing this document, I certify that I have read and understand the policies of Aspire Life Center, LLC.

Print Name: _____

Client /or Guardian Signature: _____

Date_____



NOTICE OF PRIVACY PRACTICES

33 South State Street, Dover DE 19901
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Phone: 302-530-4452
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Fax: (570) 300-1648

Email: Info@aspirelifecenterllc.com

This notice explains how your medical and mental health information may be used or shared and how you can access it. Please read it carefully.

Our Commitment to Your Privacy

Aspire Life Center, LLC is committed to protecting your privacy. We keep your health information secure and confidential, as required by law. This includes all information about your mental health care, treatment, and payment for services.

We are required by law to:

- Keep your health information private and secure.
- Provide you with this Notice of Privacy Practices.
- Follow the terms of this notice currently in effect.

How We May Use and Share Your Information

We may use and share your information with healthcare providers involved in your care. This may include therapists, doctors, nurses, or case managers who are working together to provide the **best treatment** possible.

We may use your health information to bill you, your **insurance** company, or **other payers** for services you receive. For example, your health plan may require information about your diagnosis and treatment dates before making payment.

We may use your information to **improve our services**, train staff, review performance, or manage our practice. We may also share information with your health plan for similar purposes.

We may contact you to **remind you about upcoming appointments** or to share information about other services or programs that may benefit you.

With your permission, we may **share relevant information** with a family member, friend, or other person involved in your care or payment for services.

We may share information when **required by federal, state, or local law**. This includes situations such as:

- Reporting abuse, neglect, or domestic violence.
- Preventing or responding to serious threats to health or safety.
- Cooperating with legal or law enforcement proceedings.
- Public health reporting (such as communicable diseases).



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Special Situations

We may also disclose information in the following situations:

- **Health Oversight:** For audits, investigations, or licensing purposes.
- **Workers' Compensation:** To comply with laws about work-related injuries.
- **Coroners and Medical Examiners:** To identify a deceased person or determine cause of death.
- **Military or National Security:** As required by military or authorized government officials.

Your Rights Regarding Your Health Information

- You have several important rights concerning your health information:
- You may request to review or get a copy of your medical and billing records. Requests must be made in writing. A small fee may apply for copying or mailing records.
- If you believe that information in your record is incorrect or incomplete, you may request a correction in writing.
- You may ask us to limit how your information is used or shared. For example, you can request that we not share information with your insurance if you pay for services out of pocket.
- You can request that we contact you in a specific way or at a specific location (for example, only by phone or only at work).
- You can ask for a paper copy of this notice at any time, even if you agree to receive it electronically.
- You have the right to be notified if there is ever a breach of your unsecured health information

Complaints

If you believe your privacy rights have been violated, you can file a complaint with Aspire Life Center, LLC or directly with the **U.S. Department of Health and Human Services**. You will not be penalized or retaliated against for filing a complaint.

Changes to This Notice

Aspire Life Center, LLC reserves the right to make changes to this notice at any time. Any updates will apply to all information we maintain and will be posted in our office and on our website. The effective date at the top of this notice shows when it was last updated.

Acknowledgment of Receipt

By signing below, you confirm that you have received and understand Aspire Life Center, LLC's Notice of Privacy Practices.

Printed Name: _____

Client /or Guardian Signature: _____ **Date:** _____