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| **New Client Registration** |

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| **Name:** |  | | | | | **Date of Birth:** |  | | **Age:** | |  | **Gender:** |  |
| **Social Security Number:** | | | |  | | | | | | | | | |
| **Address:** | |  | | | | | | | | | | | |
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| **May we *discretely* contact you at this mailing address?** | | | | | | | |  | | Yes | |  | No |
| **Cell Phone Number:** | | |  | | | | | | | | | | |
| **May we *discretely* contact you on your cell phone?** | | | | | | | |  | | Yes | |  | No |
| **Home Phone Number:** | | |  | | | | | | | | | | |
| **May we *discretely* contact you on your home phone?** | | | | | | | |  | | Yes | |  | No |
| **Email Address:** | | |  | | | | | | | | | | |
| **May we *discretely* contact you at this email address?** | | | | | | | |  | | Yes | |  | No |
| **Marital/relationship status:** | | | | |  | | | | | | | | |
| **Ethnic/Cultural Background:** | | | | |  | | | | | | | | |
| **Education:** | | | | |  | | | | | | | | |
| **Occupation:** | | | | |  | | | | | | | | |
| **Employer:** | | | | |  | | | | | | | | |

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| **Referal Information** | | | | | | | | |
| **How did you hear about Artisan Counseling?** |  | | | | Google/Internet Search | | | |
|  | | | | *Psychologytoday.com* | | | |
|  | | | | *Goodtherapy.org* | | | |
|  | | | | My Insurance Listing | | | |
| Other (Please Provide Details): | | | | | |  | |
| **Were you referred by a specific person? If so, who referred you to Artisan Counseling?** |  | Yes |  | No | | Referred By: | |  |

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| **eMERGENCY CONTACTs** | | | | | |
| **Name:** |  | **Phone Number:** |  | **Relationship:** |  |
| **Name:** |  | **Phone Number:** |  | **Relationship:** |  |

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| **INSURANCE INFORMATION** |
| Please be prepared to upload (client portal) or provide your counseling with your insurance card and photo ID so that we may make a copy for your file. |

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| **Primary Insurance Information** | | | | | | |
| **Name of Insurance Company:** |  | | **Policy Owner’s Name:** | |  | |
| **Policy Owners Date of Birth:** |  | | **Policy Owner’s SS#:** | |  | |
| **Insurance ID#:** |  | | **Policy Owner’s Address:** | |  | |
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| **Do you have secondary insurance?** |  | Yes | |  | | No |

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| **Secondary Insurance Information** (if applicable) | | | | | | |
| **Name of Insurance Company:** |  | | **Policy Owner’s Name:** | |  | |
| **Policy Owners Date of Birth:** |  | | **Policy Owner’s SS#:** | |  | |
| **Insurance ID#:** |  | | **Policy Owner’s Address:** | |  | |
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| **Do you have secondary insurance?** |  | Yes | |  | | No |

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| **WHAT BRINGS YOU TO COUNSELING?** | |
| *Please provide a brief summary regarding the areas of importance that contribute to seeking counseling services.* | |
| **Current Concerns:** |  |

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| **In what areas do your current concerns impact your life?** | | | | | | | | | | | |
|  | Home |  | School |  | Work |  | Community |  | Family |  | Health |
|  | Activities |  | Relationships |  | Sleeping |  | Lifestyle |  | Eating |  | Mood |
|  | Other | Please explain: | | | | | | | | | |

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| **Have you ever attempted suicide?** | | | | | | | | |
|  | Yes |  | No | **If yes, when?** | | | | |
| **Are you currently thinking about suicide?** | | | | |  | Yes |  | No |

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| **Have you ever thought about harming or killing someone else?** | | | | | | | | |
|  | Yes |  | No | **If yes, when?** | | | | |
| **Are you currently thinking about harming or killing some else?** | | | | |  | Yes |  | No |

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| **Do you use alcohol or drugs?** | | | | | | | | |
|  | Yes |  | No | **If yes, what type and how often?** | | | | |
| **Have you ever received treatment for substance abuse?** | | | | |  | Yes |  | No |
| **If yes, please provide details about substance abuse treatment services received:** | | | | | | | | |
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| **Treatment History** | | | | | |
| **Are you currently being treated by a mental health professional, medication management provider or physician for the problems noted above?** | |  | Yes |  | No |
| **If yes, please provide additional information** (Provider 1)**:** | Name of Provider: |  | | | |
| Agency Name: |  | | | |
| Contact Information: |  | | | |
| Type of Services: |  | | | |
| **If yes, please provide additional information** (Provider 2)**:** | Name of Provider: |  | | | |
| Agency Name: |  | | | |
| Contact Information: |  | | | |
| Type of Services: |  | | | |

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| **Current Medications** | | |
| Type | Dosage | Time of Day |
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| **Previous Mental Health Treatment** (dATES, NAME OF PROFESSIONAL, TYPE, WHY DISCONTINUED) | | | | |
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| **Have you ever been hospitalized for mental health treatment?** |  | Yes |  | No |
| **If yes, please provide the name of the hospital or facility and reason for hospitalization:** | | | | |
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| **Email and Texting Policy** | | | | |
| While we make every effort to protect text and email, we can provide no assurance confidentiality or security. The standard email you use at home or work is most likely not HIPAA secure and could be vulnerable to unauthorized access. Electronic communications are not appropriate if you are experiencing a crisis. We may not check email every day. With your consent, we may send automated email or text appointment reminders. Each client must weigh the benefits against the potential risk and determine the communication types they are comfortable using. | | | | |
|  | **Indicate by placing an X** | | | |
| Please indicate that you understand and agree with the above policy. I consent to using email communication: |  | Yes |  | No |
| I consent to using text message communication: |  | Yes |  | No |

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| **initial** | **Please carefully read the statement below and** |
|  | I have received and/or reviewed the general practice information which is available on the website and printed within the office. |
|  | I consent for myself (or my child) to receive behavioral health services at **Artisan Counseling.** |
|  | I have read, understand, and agree to comply with the fee policy and the **Missed Appointment Policy.** |
|  | **I have reviewed the Notice of Privacy Practices (HIPAA)** which is available both on the website and within the office. |
|  | **I consent to Berries AI Scribe to assist with development of clinical documentation required for third party reinvestment and other documentation standards.** I am aware that I can revoke my consent from this service at any time by informing my counselor or the Artisan Counseling administrative team. |
|  | **I will use my insurance benefits.** I understand that I am responsible for all co-payments, cost share payments, or out of pocket payments for services provided to me. I authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. |
|  | **I understand that I am responsible for any fees denied or not covered by my insurance company.** |
|  | **I acknowledge responsibility for any and all collections feed incurred by Artisan Counseling, which may include any fees charged by a collection agency, attorney, court costs, and all other expenses necessary for the collection of an outstanding balance.** |
|  | **I will self-pay for services and will not use insurance**. |
|  | I have reviewed the Artisan Counseling **collections process** (past due balance) as outlined in the General Practice Information packet. |

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| **I have read and understand the conditions outlined above:** | | | |
| Client signature: | Handwritten signature not required if signing electronically | Date: |  |
| Parent/Guardian (if applicable) Signature: | Handwritten signature not required if signing electronically | Date: |  |

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| **Authorization for release of information for Physician** | |
|  | **YES**, I authorize a release of information to my PCP and/or psychiatrist. **Please complete the authorization of information form on the next page and upload it into your client portal.** You are able to electronically sign the document after uploading the completed form to the portal. |
|  | **NO**, at this time I do not authorize a release of information to my PCP and/or physiatrist. Please upload this form back into your client portal and complete an electronic signature. Do not compete the information requested on the next page of this document. |

I, (Client Name)       (date of birth)       , hereby authorize Artisan Counseling, LLC and (Counselor Name) , to disclose to and/or obtain from the below person(s) or organization:

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| --- | --- | --- | --- |
| Name: |  | Company/Agency: |  |
| Title: |  | Phone Number: |  |
| Email: |  | Fax: |  |

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| **Type of information to be disclosed** | | | | | |
|  | Evaluations |  | Diagnosis |  | Treatment Plan |
|  | Course of Treatment |  | Medical/Hospital Records |  | Psychological/Medical Test Results |
|  | Psychotherapy Notes |  | Intake/Discharge Documents |  | SUD Treatment Information |
|  | Other (List): |  | | | |

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| **Purpose of such disclosure** | | | | | | |
|  | Ongoing Treatment |  | Medical Care | |  | Consultation |
|  | Evaluation |  | Transfer | |  | Legal Issues |
|  | Coordination of Care |  | Other (List): |  | | |

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| **Expectations of disclosure:** |
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The designated information about me  **may or  may not** be transmitted by fax, electronic email or other electronic file transfer mechanisms. , (Artisan Counseling) and the above designated person  **may or  may not** discuss by telephone the content of the information released.

This consent is in effect until        (date, E.g. One year from today’s date) or  90 days after the closure of counseling services. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed counselors (LPC) and social workers (LCSW) except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to abuse or neglect of children and the elderly.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

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| Client Signature: | Handwritten signature not required if signing electronically | Date: |  |
| Parent/Guardian (if applicable) Signature: | Handwritten signature not required if signing electronically | Date: |  |

Revised 1.13.25