PROVIDER:

REGISTRATION INFORMATION

Referring Doctor:

CLIENT INFORMATION

CLIENT FULL LEGAL NAME:	DATE OF BIRTH	GENDER ☐MALE ☐FEMALE ☐TRANS

MARITAL STATUS ☐SINGLE ☐MARRIED ☐PARTNERED ☐SEPARATED ☐DIVORCED ☐WIDOWED ☐OTHER	EMPLOYMENT STATUS ☐FULL TIME ☐PART TIME ☐SELF-EMPLOYED ☐RETIRED ☐ACTIVE MILITARY	STUDENT STATUS ☐FULL TIME ☐PART TIME

ADDRESS	CITY/STATE/ZIP

HOME PHONE	CELL PHONE	WORK PHONE

EMAIL ADDRESS	OK TO DISCUSS SCHEDULING VIA EMAIL? ☐YES ☐NO OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? ☐YES ☐NO

EMERGENCY CONTACT

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE

RESPONSIBLE PARTY (IF MINOR OR GUARDIAN)

FULL LEGAL NAME	RELATION TO CLIENT ☐BIOLOGICAL PARENT ☐STEP-PARENT ☐LEGAL GUARDIAN ☐MINOR

ADDRESS	CITY/STATE/ZIP

PHONE	LEAVE MSG? ☐YES ☐NO	EMAIL ADDRESS	OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? ☐YES ☐NO

INSURANCE INFORMATION Copy of both sides of the insurance card(s) needed at intake.

PRIMARY INSURANCE NAME #1

POLICY #:	GROUP #:	RELATIONSHIP TO CLIENT ☐SELF ☐SPOUSE ☐DEPENDENT

POLICY HOLDER:	SS #:

INSURED DATE OF BIRTH:	EMPLOYER:

SECONDARY INSURANCE NAME #2

POLICY #:	GROUP #:	RELATIONSHIP TO CLIENT ☐SELF ☐SPOUSE ☐DEPENDENT

POLICY HOLDER :	SS #:

INSURED DATE OF BIRTH :	EMPLOYER:

ALL COPAYS AND BALANCES ARE DUE IN FULL AT THE TIME OF YOUR APPOINTMENT

CLIENT FULL LEGAL NAME:	**DATE OF BIRTH:**

PRIVATE PAY Payment due IN FULL at the time of Service.

SERVICE DESCRIPTION (EXAMPLE: INTAKE)	RATE/UNIT (EXAMPLE: $200/45-50 MIN)	SERVICE DESCRIPTION	RATE/UNIT
	$ /		$ /

IMPORTANT SIGNATURES

CLIENT FULL LEGAL NAME	DATE OF BIRTH

if client is a minor, please print full legal name of parent/guardian(s) signing on behalf of the client:

PRINT FULL LEGAL NAME	RELATIONSHIP TO CLIENT
PRINT FULL LEGAL NAME	RELATIONSHIP TO CLIENT

INSURANCE BILLING

I authorize _____(hereandafter called Medical Practice) to release any medical information to our billing company for paper & electronic billing of your insurance company. I authorize my insurance company to assign benefits to Medical Practice, I understand that I am responsible for payment for services rendered by Medical Practice regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify the Medical Practice immediately whenever I have changes in my health plan coverage.

ACCOUNT RESPONSIBILITY

I am responsible for payment to Medical Practice for all services rendered, due at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement, the Medical Practice reserves the right to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names the Medical Practice as a creditor in any bankruptcy filing.

INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES

I am consenting to treatment and have received and understand the contents of the Policies, including the Notice of Privacy Practices (HIPAA).

My signature below indicates that I have been provided a copy of, and that I fully understand & agree to all of the terms and conditions of the Policies. If I have questions, the information has been explained and/or summarized for me.

SIGNATURE(S) (CLIENT OR LEGAL GUARDIAN)	DATE
SIGNATURE(S) (LEGAL GUARDIAN)	DATE

"

IMPORTANT NOTICE TO ALL PATIENTS

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL INSURANCE POLICY. MANY INSURANCE POLICIES HAVE EXCLUSIONS, AND MOST HAVE DEDUCTIBLES, AND CO-PAYMENTS / CO-INSURANCE. SOME INSURANCE POLICIES MAY NOT COVER OUR SERVICES.

IT IS IMPORTANT FOR YOUT O CHECK WITH YOUR INSURANCE CARRIER TO DETERMINE IF THE PROVIDER YOU ARE SEEING IS LISTED AS AN “IN-NETWORK” PROVIDER. IF THEY ARE NOT LISTED AS AN “IN-NETWORK” PROVIDER YOU MAY HAVE A HIGHER DEDUCTIBLE AND OR CO-PAY.

REGARDLESS OF INSURANCE COVERAGE, YOU ARE RESPONSIBLE FOR ALL BILLS NOT COVERED BY YOUR INSURANCE POLICY.

_____ _____

Signature of Patient/Guardian Date

VanderWeele & Associates Counseling
4341 S. Westnedge Ave STE 1203 Kalamazoo MI 49008
Telephone: 269-823-2675

CLIENT EXPECTATIONS POLICY

OUR PRACTICE

The caring team of psychotherapists at VanderWeele & Associates Counseling understands and respects that it takes courage, motivation, and integrity to seek help. We are available to support and assist you as you take this first step toward wellness.

TREATMENT FOCUS

VanderWeele & Associates Counseling focus is to help individuals heal, energize, and become aware of their inner strengths. We achieve this by providing a neutral safe space, listening to your concerns, and customizing a treatment plan. We utilize various treatment approaches including, but not limited to: cognitive behavioral therapy (CBT), family systems therapy, insight-oriented therapy, EMDR (Eye Movement Desensitization Reprocessing), Dialectical Behavior Therapy (DBT) techniques, as well as other evidence-based models of therapy.

OUR PATIENT PROMISE

VanderWeele & Associates Counseling promise to provide non-judgmental therapy services and treat you with respect and dignity on your journey to wellness. Our goal is to help you grow from your struggles, heal from your pain, and move forward to where you want to be in your life.

EMERGENCY NEEDS

In case of any emergency, our clients are responsible to first contact 9-1-1 for any of their life-threatening needs/emergencies or go to the nearest emergency room immediately. Clients can also reach out to the Gryphon Place via phone at 2-1-1 or their 27/7 crisis hotline at (269) 381-HELP in between their scheduled therapeutic sessions for issues including suicide prevention and helping navigate conflict and crisis when in an emergency situation. Gryphon Place also provides their 27/7 crisis text services that can begin by texting 898-211.

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COMMUNICATION WITH THERAPIST

While clients are welcome to reach out to their therapist between normally scheduled sessions for all matters, either by phone call, text, or e-mail. Agency policy does not require therapists to respond outside of their normally scheduled session times. Each therapist manages additional communications as their needs dictate. Self-care and healthy boundaries allow therapists to manage their own physical and mental health to ensure quality care for their clients. Therapists will return their clients' communication in a timely manner to the best of their abilities however, it is sometimes not feasible to do so. Again, please see the Emergency Needs section above for what to do in a crisis.

We value you as a client and hope to help you with your future endeavors; however, we can only accomplish this with your understanding of your obligations set forth in this policy and consistency with treatment.

My signature below indicates that I have been offered a copy of, and that I fully understand and agree to all of the terms and conditions of the Policies listed above.

_____ _____

Signature of Patient/Guardian Date

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CANCELLATION POLICY

CANCELLATIONS AND MISSED APPOINTMENTS

The client is expected to attend each scheduled session on time. Since your appointments involve the reservation of time specifically for you, and out of respect for your therapist and our other clients, a minimum of 24 hours' notice is required for rescheduling or canceling an appointment.

The only exception to this cancellation policy is in the event of a serious or contagious illness or emergency. Some examples of emergencies are car accidents, deaths in the family or extreme illness. This cancellation policy also applies even if missing the appointment was an unintentional act.

FREQUENT CANCELLATIONS OR MISSED APPOINTMENT

Frequent cancellations (Three or more in four months or three consecutive) and/or missed appointments (no shows) in which the therapist was not given a minimum of 24 hours' notice, will result in the termination of treatment with our practice. If this is your first cancellation or missed appointment and you have arranged with your therapist to have recurring appointments, the next recurring appointment will stay in the calendar. The recurring appointment will be removed after the second consecutive cancellation or missed appointment and you will be taken off the therapist's recurring appointment list and put on their recurring cancellation list. When this has occurred, you are responsible to reach out to your therapist on Sundays to see if the therapist has any cancelations for the week. If the therapist has a cancellation for that week, the client may be scheduled in that timeslot.

Although your therapist may send you text or email reminders about upcoming appointments, this is done as a courtesy and only if you consent to receive such communications by providing us with your e-mail address and/or cell number. It remains your sole responsibility to keep track of and timely attend all scheduled therapy appointments, whether you receive the text or e-mail reminder. It is your responsibility

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to inform the therapist if your phone number or e-mail has changed. After three consecutive cancellations (with less than 24-hour notification) or no shows, you will not be able to schedule another appointment and will be referred to another mental health practice.

FEES FOR NO-SHOWS & LATE CANCELLATIONS

Anytime you fail to attend a scheduled appointment without giving appropriate prior notice of cancellation, ***you will be charged $75 for the unattended session***. This amount will be owed by you the client and cannot be billed to your insurance provider. The payment for this amount will be due to the therapist before your next scheduled appointment. This payment can be made via check, cash, Venmo, or calling in a payment to the office number (269) 823-2675. If payment is not made before the next scheduled appointment time the appointment will not be able to occur.

We value you as a client and hope to help you with your future endeavors; however, we can only accomplish this with your understanding of your obligations set forth in this policy and consistency with treatment.

My signature below indicates that I have been offered a copy of, and that I fully understand and agree to all of the terms and conditions of the Policies listed above.

_____ _____

Signature of Patient/Guardian Date