

CLIENT REGISTRATION FORM

Client's Last Name	First Name	Middle Initial
Primary Phone	Email Address	Date of Birth / /
Street Address	City	State Zip
Referred by / found provider through:		
<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Doctor <input type="checkbox"/> Mental Health Provider <input type="checkbox"/> Website (please list): _____		
<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Agency <input type="checkbox"/> Family / Friend <input type="checkbox"/> Other (please list): _____		
Occupation	Employer	Social Security Number
Emergency Contact	Relationship to Client	Phone
Legal Custodian (if applicable)	Relationship to Client	Phone

Insurance Information

Primary Insurance	Subscriber's Name (if different from client)	
Subscriber's DOB (if different from client)	Subscriber's SS # (if different from client)	Client's Relationship to Subscriber
ID #	Group #	Copay Amount
Annual Deductible \$	Deductible Met?	If not, how much remains?
Insurance Contact Information (back of card)		
Tel:	Address:	

I certify that the above information is true to the best of my knowledge. If applicable, I authorize that my insurance benefits be paid directly to the clinician. I also authorize my clinician or insurance company to release any information required to process my claims. I permit a copy of this authorization to be used for these purposes as required and understand that I may revoke this authorization in writing at any time. I further understand that I am financially responsible for any balance due, and that this is to be paid at the time of service by paypal, google wallet, check, cash, or money order made payable to Beatrix von Watzdorf. In the event that I failed to procure a required referral or authorization for service, I agree to pay Beatrix von Watzdorf the appropriate rate for services. If I fail to provide *at least 48 hours notice prior to missing an appointment*, I agree to pay the full session fee.

CLIENT / GUARDIAN SIGNATURE

DATE

INFORMED CONSENT: In order to receive the most benefit from the services you will be receiving, please review the following information concerning my services, policies, and responsibilities. If you have any questions, I will be pleased to discuss these further with you.

Professional Services

I am a Licensed Professional Counselor (LPC) and trauma specialist. To become an LPC, a clinician must have successfully completed extensive post-graduate studies in an accredited counseling program, provided numerous years of supervised post-graduate clinical work, and passed the National Counselors Examination (NCE). My Master of Science degree is in Professional Counseling, with specialization in post-traumatic stress, which I received from Georgia State University. I have also been certified by the National Board of Certified Counselors (NBCC) as a Nationally Certified Counselor (NCC). Currently I provide counseling, meditation, and psychoeducational services to adults with a variety of presenting issues via in person and telemental health sessions. I use individual and group treatment interventions including cognitive behavioral therapy, existential therapy, and mindfulness.

Policies

Therapy sessions typically are 50 minutes in length and occur on a weekly basis. The duration of treatment varies on a case-by-case basis depending upon a client’s presenting issues, desired outcomes, insurance coverage, and availability to participate in treatment. Payment is due when services are rendered and may be made by paypal, google wallet, cash, check, or money order made payable to Bea von Watzdorf. I also accept certain insurances, including Blue Cross Blue Shield, and provide billing statements with information required by most insurance carriers to file for out-of-network reimbursement. Nevertheless it remains clients’ responsibility to ensure that visits are covered by their insurance plan; consequently clients are advised to contact their insurance company to inquire about the extent and provisions of their policy. For individual therapy, my fees are: \$150 initial evaluation (50 minutes), \$225 initial evaluation (75 minutes), \$150 therapy session (50 minutes), and \$225 therapy session (75 minutes). Sliding scale is available depending on financial need and availability.

To receive a benefit from treatment, it is important to keep scheduled appointments. If unforeseen circumstances arise, please let me know as far in advance as possible. With the exception of extreme emergencies, any appointment not cancelled 48 hours in advance will be considered a late cancellation and incur the full session fee. Please note that insurance carriers do not reimburse for missed appointments.

Responsibilities & Privacy Practices

As a client, it is your right to receive competent and timely treatment and services, delivered with respect and dignity by a licensed mental health professional. You are also entitled to participate in the planning of a course of treatment designed specifically to your needs and in periodic reviews of your progress.

Privacy Practices: By entering into a professional clinical relationship, you can expect your communications with me to be held in confidence and not to be released without your written permission, except as required by law* and outlined in any signed *Authorization to Release Confidential Information* form. (*Legally mandated exceptions are: (a) for court-appointed attorneys for commitment proceedings; (b) for possible child abuse; (c) in case of duty to warn; (d) for third party payers; (e) and for state agencies, correction institutions and county prisons if a client is referred by them for treatment.) You can also expect to: receive quality care regardless of race, sex, age, ethnicity, national origin, religious preference, marital status, sexual orientation, or disability; be informed about the outcomes of care, including unanticipated outcomes, and referred to another provider if necessary; and be assessed for sliding scale eligibility at your request, if the cost of services is beyond your ability to pay. (Note: Please sign below to confirm that you have read and understood the above information.)

CLIENT / GUARDIAN SIGNATURE

DATE