Hope and Restoration Pathways, Inc.

REGISTRATION FOR COUNSELING SERVICES AND/OR THERAPY/SUPPORT GROUP SERVICES

CLIENT INFORMATION

Name:____
(Last) (First) (Middle Initial) (Prefered name)

Mailing Address:____
(Street/PO Box) (Apt.) (City) (State) (Zip)

Home Phone:____________________ Work Phone:____________________ Ext. #:_______ Cell:____________________

E-mail Address:____

Social Security #:__________________________ Sex: ❒M ❒F Birth date:____________________ Age:__________

Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed ❒Other ____________________

Ethnicity: ❒American Indian/Alaskan Native ❒Asian ❒African/American ❒Hispanic ❒White ❒Hawaiian/Pacific Islander ❒Other____________

GUARANTOR INFORMATION (Person who is responsible for payment) Check if client responsible _________

Name:____ Birth date:____________________
(Last) (First) (Middle Initial)

Mailing Address:____
(Street/PO Box) (Apt.) (City) (State) (Zip)

Relationship to client: ❒Spouse ❒Mother ❒Father ❒Sibling ❒Other (relationship) ____________________

Home Phone:____________________ Cell Phone: ____________________ Soc. Sec. #:____________________

INSURANCE INFORMATION

NOTE: HARP will file insurance in cases when your therapist is contracted with your insurance plan. Complete the following ONLY if we are filing claims for you.

Primary Insurance Co. Name:____ Phone:____________________

Member's Name: ____________________ Relationship: ❒Self ❒Spouse ❒Parent ❒Other ____________________

Employer: ____ Phone:____________________

Birth date:______________ Member ID #:____________________________ Group ID #:____________________

Secondary Insurance Co. Name:____ Phone:____________________

Subscriber's Name:____________________ Relationship: ❒Self ❒Spouse ❒Parent ❒Other ____________________

Employer:____ Phone:____________________

Birth date:______________ Member ID #:____________________________ Group ID #:____________________

CONSENT TO RELEASE INFORMATION

I hereby consent for HARP to contact my primary care physician, psychiatrist, or other health care provider as noted below regarding my treatment, if deemed necessary. This consent shall remain in force during my treatment at HARP and for 120 days following my last visit unless revoked by me in writing.

Physician Name: ____ Phone #: ____________________

Address: ____

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I hereby consent for HARP to contact the person(s) below as deemed necessary regarding the information indicated. This consent shall remain in force during my treatment at HARP and for 120 days following my last visit or after services have been paid in full unless expressly revoked by me in writing.

Name	Relationship	Daytime Phone #	Evening Phone #	OK to leave message	Financial Info.	Medical Info.	Other (Specify)
				❑	❑	❑	
				❑	❑	❑	
				❑	❑	❑	

CONSENT FOR CONTACT

I agree to receive follow-up contact from HARP, including, but not limited to, informatin regarding upcoming seminars/events, educational information, updates, etc. I understand that I can revoke this consent at any time. By initialing, I provide my consent. Initials: ___________

ACKNOWLEDGEMENTS

By signing below, I acknowledge the following:

- I have received a copy of the "Notice of Privacy Policies and Clients Rights."
- I have consented to treatment provided by HARP and its employees or contract staff. I understand HARP serves as an intership site for graduate social work and counseing students. I may be seen by an intern who will provide care to me under the supervision of a licensed professional. I will be made aware of this before services are initiated.
- I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of HARP. I authorize HARP to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that HARP may release objective clinical information related to my diagnosis and treatment that may be requested by my insurance company (if applicable) or its designated agent.
- I authorize and request my insurance plan (if applicable) to make direct payment to HARP for the amount due for services rendered to myself or others covered by the above insurance plan(s). I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered. I understand that this consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this consent will be null and void six months after the final payment has been received on this account. This consent is subject to state and federal confidentiality regulations.
- I agree to take full responsibility for the entire amount due for all services rendered. If the therapist is contracted with my insurance company, I will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by the insurance plan. If I do not inform HARP in a timely manner of any changes to my insurance coverage, I understand that I may need to pay for services in full if payment is denied in part or in full by my insurance carrier. I further understand that I may not be able to schedule appointments if my account becomes delinquent and/or my account is turned over to collections.
- I understand that my client records are the property of HARP and shall be treated as confidential; that my records will not be released without my written consent or as provided by the laws of the State of North Carolina. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing.
- I acknowledge that if I need to cancel or reschedule an appointment I will provide a minimum of one business day's notice. Otherwise, I understand that I am subject to the full charge for the missed appointment and am responsible for payment in full.
- I acknowledge that HARP does not provide after hours emergency care as therapists are not always available to address emergency concerns. I am responsible for seeking care at the nearest emergency center when my therapist is not available.
- I certify that all the information I have provided above is true and correct.

Client Signature: ___________________________ Date: ___________________

Guarantor's Signature (if not client): ___________________________ Date: ___________________

Client/Guardian Name (please print): ___________________________

PLEASE COMPLETE THE FOLLOWING SECTION WHEN APPLICABLE

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

I certify that I am the ❒ father, ❒ mother, ❒ legal guardian and have legal custody of the above named client. I, hereby, give my authorization and consent for the client to receive outpatient assessment/treatment from ___________________________ .
I understand it is the policy of HARP that the parent/guardian bringing the client for treatment is responsible for payment at the time services are rendered. I will be responsible for payment of the treatment regardless of any financial arrangement for payment of tservices rendered, either oral or written, with the client's other parent or responsible party. I understand that HARP assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements for the client's medical care.

Parent/Guardian Name (please print): ___________________________

Parent/Guardian Signature: ___________________________ Date: ___________________

Staff Witness: ___________________________ Comments: ___________________________