CLIENT REGISTRATION

Name:____

Address:____

City, State, Zip Code____

Home Phone:____________________Cell:______________________May we text? Yes/No

Email:____ May we email? Yes/No

DOB:__________________________

Marital Status: Never Married/Domestic Partnership/Married/ Separated/ Divorced/ Widowed

Preferred Pronouns: He/Him She/Her They/Them other___________________

Emergency Contact:______________________________ Phone:____________________

Primary Care Physician:___________________________ Phone:____________________

Billing Information

Primary Ins Co:________________________ Policy No:____________________________

Group No:____________________________

Subscriber:____________________________ DOB:________________________________

Insured's Employer:_____________________ Phone:_______________________________

I, ___________________________________ do hereby give authorization for direct payment from my insurance company to Rosemary Huber, LPC. I also authorize Rosemary Huber to furnish any information regarding my illness, care and treatment to my insurance company and/or attorney who may be directly involved with my care and treatment.

Client's Signature:____

Date:____________

Rosemary Huber, LPC

Counseling + Psychotherapy

6515 Main Street Unit 6LL

Trumbull, CT 06611

CLIENT REGISTRATION

Please Read and Initial the Following Statements

1. I understand that I must inform the office 24 hours in advance in the event of an appointment cancellation. If 24 hours is not given, I agree to be responsible for a missed appointment charge and I understand that I may be terminated from the practice for repeated missed appointments.

Initial ___________________________

2. I understand that I am responsible for the deductible and copay according to the terms and conditions of my agreement with my insurance company. I understand that I am expected to pay the amount of my deductible and copay at the time of my appointment.

Initial___________________________

3. I understand that payment for services not covered by my medical insurance such as reports, collaboration with schools or other third parties, disability assessments, etc. is my responsibility.

Initial __________________________

Thank you for your cooperation in these matters.

Rosemary Huber, LPC
Counseling + Psychotherapy
6515 Main Street Unit 6LL
Trumbull, CT 06611
Rosemary Huber, LPC
Counseling + Psychotherapy

INFORMED CONSENT

Confidentiality:

Everything discussed in therapy sessions is confidential and will not be revealed to other persons without your approval except as required by state or federal law and/or under the following conditions:

1. You are in imminent danger of harming yourself or others:
2. Child or dependent adult abuse by you or others is reported to the therapist;
3. Court Order

Safety

You are responsible for keeping yourself safe throughout the course of our work together. If you cannot or will not assume this responsibility and force me to activate legal means (i.e., involuntary commitment) to keep you safe then we will no longer be able to work together. I will help you find another therapist who will be able to assist you. If you are feeling like hurting yourself or someone else, tell me, I will help you find the resources you need and there will be no interruption in our treatment.

Fees and Cancellation Policy:

Payment is required at the end of each session. Checks should be made payable to Rosemary Huber, LPC. If you need to cancel your appointment please call within 24 hours. You will be charged for sessions that you fail to attend without having provided appropriate (24 hour) notice.

Please note I cannot bill for any missed appointment to your insurance carrier as that would be fraud. If you miss a scheduled visit, and you do not call my office within seven days to reschedule, I will accept that as your notice that you have terminated this agreement and that you wish to discontinue counseling with me.

If you have any questions about these policies, I will be glad to discuss them with you.

With your signature below you affirm that you understand all policies and that you agree to abide by all conditions stated above.

____ ___________________________

Client Signature Date