LIFE REFLECTIONS, LLC

CONFIDENTIAL CLIENT INFORMATION

Welcome to my practice. Please fill out the following questions as completely as possible.
PLEASE PRINT OR WRITE LEGIBLY

Client's Name	Last First Middle Preferred Name	**Marital Status** __Single __Married __Partnered __Separated __Divorced __Widowed
Client's Address	**Must be physical address, not P.O. Box** Street:	
	City:	
Phone	Home: Cell: Work:	
	Age: Date of Birth: / / Birth Sex: Gender You Identify As:	
Education	No. of years: Degree: Field:	
Occupation	Social Security No:	
Spouse/ Partner	Name: Age: Occupation: Years Together:	

Children: Name/ Age

Were you raised by: Both parents: __ Single parent:__ Relative __ Other__

Father's Name: Age: Occupation:

Mother's Name: Age: Occupation:

Brothers and sisters (including yourself) in birth order: Name/Age:

In your family was there a history of: Alcoholism __Substance abuse __Mental illness __Prolonged physical illness__
What kind:

Current Medications and Dosage: Prescribing Physician:

Significant medical problems:

Have you had previous psychiatric care and/or counseling? __Yes __No
If yes, give name of clinician Degree/License Sessions from to

Have you ever been hospitalized for substance abuse, alcoholism, eating disorders, or other psychiatric disorders? __Yes __ No
If yes,

Emergency Contact: Name/Phone number

Client's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

NEW CLIENT BILLING SHEET

CLIENT NAME:_____ DOB:_____

ADDRESS:_____

PHONE: _____ SS NO: _____

INSURANCE:

NAME OF INSURANCE: _____

Telephone No. (On back of insurance card): _____

NAME OF INSURED: _____ DOB: _____
(Must be completed in order to bill insurance)

ID NO. OR SS NO: _____

PLACE OF EMPLOYMENT: _____

I hereby instruct and direct insurance company to pay by check made out and mailed to:

Life Reflections, L.L.C.
202 South Randolph Ave.
Elkins, WV 26241

or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize therapist to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand I am responsible for my insurance information being correct and up to date. I also understand that regardless of what the insurance pays I am responsible for all charges. Any monies received by the clinician from the above insurance companies over and above my indebtedness will be refunded to me when my bill is paid in full I authorize the release of any medical benefits to this provider for services rendered.

CLIENT'S SIGNATURE: _____ DATE: _____
SPOUSE'S SIGNATURE: _____ DATE: _____
PARENTS/GUARDIAN'S SIGNATURE: _____ DATE: _____

Clinical use only:
DIAGNOSIS: _____ INITIAL DATE OF SERVICE: _____
CLINICIAN: _____

Scheduling & Payment Policy

I understand when I schedule an appointment at Life Reflections, the time slot and therapist are reserved for me and therefore are not available to serve others at that time. Therefore, I agree to kindly give 24 hours notice of cancellation or pay full price for the missed appointment.

Court Policy

Because the relationship between the therapist and client is confidential, it is this facility's policy not to appear in court for any reason. We feel this break in confidentiality would limit the expected benefits from the therapy and place the client in more guarded behavior during sessions. Your signature indicates you have been made aware of this policy and are in agreement.

Having read and understood the above, I agree to these limits of confidentiality as well as the scheduling and payment policy.

_____

Name of Client or Guardian Date

Signature of Client or Guardian

LIFE REFLECTIONS, LLC

202 South Randolph Ave.* Elkins, WV 26241
(304)637-1002

Life Reflections LLC

202 So Randolph Avenue
Elkins, WV 26241
(304)637-1002

HIPPA Compliance Policy Manual

Notice of Therapists' Policies and Practices to Protect the Privacy of Your Health Information

Purpose of this Notice:
We respect the privacy of personal information and understand the importance of keeping this information confidential and secure. This notice describes how we protect the confidentiality of the personal information we receive.
As our client, we want you to feel comfortable knowing that any information we have will be handled with care and that we have procedures in effect to protect client information in all settings. We do not disclose your identifiable health information without your written consent unless there is a legal exception, such as a court order.

Health Information that can Identify you is only used:

- To provide treatment
- To coordinate your care
- For billing
- For quality assessments
- For accreditation and compliance with regulators

Types of Personal Information Collected:
We collect personal information needed to treat our clients. Some of this information is provided in medical history forms and correspondence (such as address, Social Security Number, and dependent information). We also receive personal information (such as eligibility and claims information) through our affiliates, employers, insurers, and health care providers. We retain this information after a customer's coverage ends. We limit the collection of personal information to that which is necessary to administer our business, provide quality service and meet regulatory requirements.

We disclose confidential information to our business associates (clinicians, hospitals, and other health care professionals and facilities) only if our affiliates and business associates protect your privacy and abide by privacy laws as well. If we receive requests for identifiable health information, you will be given the opportunity to consent to or deny the release of your information in writing.

Protection of Personal Information:
We treat personal information securely and confidentially. We limit access to personal information to only those persons who need to know that information in order to provide our services to customers. These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law.

We meet strict physical, electronic, and procedural security standards to protect personal information and maintain internal procedures to promote the integrity and accuracy of that information.

We may share any of the personal information we collect with our affiliates as permitted by law with your permission in writing. We also may disclose this information to non-affiliated entities or individuals as permitted or required by law. Non-affiliates with whom we may disclose information as permitted by law include our attorneys, accountants, and auditors, a clients authorized representative, health care providers, third party administrators, insurers, and law enforcement or regulatory authorities.

ACKNOWLEDGEMENT OF RECEIPT

By signing below, I acknowledge that I have received a copy of Life Reflections, LLC's notice of Privacy Practices.

Client's Printed Name:_____

Printed Name of Parent/Guardian of client: _____

Client's Signature/Date: _____

Signature/Date of Parent/Guardian of client: _____

Life Reflections, LLC
202 South Randolph Ave.
Elkins, WV 26241
304-637-1002

We can send you and appointment reminder by email. The appointment reminder will include only the date and time of your appointment and your service provider name. We will not encrypt the messages. Health care information sent by regular email could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, we need you to confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

Client Signature: _____ Date: _____

Email Address: _____