

**Lighthouse Family Center, Ltd.**

**REGISTRATION FORM**

**CLIENT INFORMATION:**  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc Sec#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_

Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Race/Ethnicity: O Asian O Black/African American O Native American/American Indian O Caucasian O Hispanic O Middle Eastern

**GUARANTOR INFORMATION:** (Person responsible for charges not covered by insurance)

\_\_\_\_\_Same as above

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc Sec#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

Primary:

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary:

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize Lighthouse Family Center LTD. to release such information in connection to

my treatment to the above-named insurance company(ies) for the purpose of processing insurance claims.

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize payment of the benefits otherwise payable to me by the designated insurance company(ies) directly to Lighthouse Family Center LTD. Payments shall not exceed regular charges.
**\*\*\*PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED\*\*\***

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Client/ Parent / Guardian / Legal Representative**

 **REMINDER CALLS**

In order to provide our clients with appointment reminder calls, Light House Family Center LTD., requires written permission from the client / parent / guardian:

O I would like an appointment reminder call

O I would like a text message

**Phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Schedule of Fees:**

* **Diagnostic Assessment/ Intake Interview** = $150 per 60-minute session
* **Individual Counseling** = $150 per 53-to-60-minute session; $100 per 38 to 52 – minute session
* **Group Counseling** = $45 per person per hour
* **Evaluation/ Assessments** = Fees vary and will be reviewed with each client depending upon the therapeutic purpose of the evaluation/ assessment being completed, if applicable.
* **Self-Pay for Non-Insured – (excludes any sessions, report, and/or testing fees associated with an evaluation)**
	+ **Diagnostic Assessment/Intake Interview =** $150 per 60-minute session.
	+ **Individual Counseling =** $100 per 53-to-60-minute session; $80 per 38 to 52-minute session.
* **Self-Pay for Insured Out of Network – (excludes any session, report, and or testing fees associated with an evaluation).**
	+ **Diagnostic Assessment /Intake Interview =** 60-minute session, billed at the rate of reimbursement of the individuals in network insurance plan.
	+ **Individual Counseling =** 53 to 60 - minute session; 38 to 52 – minute session, billet at the rate of reimbursement of the individuals in network insurance plan.

**Financial Policies:**

* Fees for reports, testing, letters, summaries, telephone consultation, review of other medical records, and other services WILL NOT be billed to Insurance, Medicaid, or most other Third- Party payers, and therefore; become the responsibility of the client.
* There will be a $25 charge for checks returned for non-sufficient funds.
* We reserve the right to charge for your visit if there is not a 24- hour notice of cancellation. This WILL NOT be billed to Insurance, Medicaid, or other Third- Party payers, therefore, become the responsibility of the client.
* We reserve the right to refuse to provide future services should a history of no-shows and/or late cancellations be noted.
* Deductibles and ci-pay amounts, and money due for services not covered by another payer, are due at the time of each visit.
* Although we bill your insurance company and/or third-party payer for the services provided, YOU are ultimately responsible if payment is not received in a timely manner.
* If your bill for services rendered is not paid promptly, we will turn your account over to a collection agency. However, we will make every effort to avoid this by working with you to develop a schedule for timely payments on your account. Additional collections fees may be added to your account if involving a collection is necessary.
* We accept Visa, MasterCard, Cash, Personal Checks, and Money Orders for your convenience.
* Any self-pay agreements made prior to 5/2021 will be upheld by Lighthouse Family Center, Ltd.

**I have read, and fully understand, the above provisions.**

**I give permission to, and request that, Lighthouse Family Center, LTD., bill my insurance, Medicaid, or third-party payer for services rendered to me and my family, I understand that it is still my responsibility to ensure that my bill from Lighthouse Family Center, LTD is pain in a timely manner.**

**If, for any reason a portion of the entire bill is not paid by insurance, Medicaid, or any Third-Party payer, I agree to make arrangements for timely payments to Lighthouse Family Center, LTD.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Client/ Parent/Guardian Date**



 **PRIMARY CARE PHYSICIAN COMMUNICATION FORM**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

O Check here if you do not have a primary care physician.

 **AUTHORIZATION TO DISCLOSE INFORMATION**

I understand that my records are protected under the applicable state law governing healthcare information that relates to mental health services and under the federal regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), and they cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken in regard to it. This release will automatically expire twelve (12) months from the date signed.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print clients name) (Print Therapist name)

 O To release applicable information TO my primary care physician

 O NOT to RELEASE information to my primary physician

 O To receive the following information FROM my primary care physician

**X:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(Signature of client / parent / guardian)**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*OFFICE USE ONLY\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

Your patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, was recently seen in our office for outpatient counseling. We hope that the following information will be helpful in coordinating this patient’s care. Please call if further information is needed.

Date of initial consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of next appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis and brief description of presenting problem (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treating clinician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Locations:

-2416 Whipple Ave. NW Canton, OH 44708 Sincerely,

-4526 Stow Rd. Suite A. Stow, OH 44224

-213 Market Ave. N Suite 200. Canton, OH 44702 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Signature, Title, Credentials*



**PERMISSION FOR TREATMENT & INFORMED CONSENT**

I hereby authorize *Lighthouse Family Center, Ltd.* to provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with the following services:

 \_\_\_\_\_ Individual Psychotherapy

 \_\_\_\_\_ Psychological Testing / Evaluation / Assessment

 \_\_\_\_\_ Family Counseling

 \_\_\_\_\_ Group Counseling

 \_\_\_\_\_ Custody Evaluation

 \_\_\_\_\_ Parent Consultation

 \_\_\_\_\_ CPST – Community Psychiatric Supportive Treatment

 \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that mental health services sometimes carry a risk of undesirable side effects and am aware that I am entitled to an explanation of each possible side effect. I further understand that only those services listed above will be provided unless I give signed authorization for additional services.

In the event that the therapist feels that you or any family members are danger, they have an ethical obligation to breach confidentiality, as they are Mandated Reporters and have a Duty to Warn. This includes but is not limited to: Abuse, Neglect, Homicidal or Suicidal ideation.

Confidential information about your treatment will not be disclosed unless all persons who participate in treatment provide permission to release such information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Signature of Client / Parent / Legal Guardian*** ***Relationship to Client Date***

**Client Rights, Civil Rights, and Grievance Procedures**

I have received a copy of Lighthouse Family Center, Ltd., Client Rights, Civil Rights, and Grievance Procedures, either on paper or have been given access to a copy through the patient portal.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

***Signature of Client / Parent / Guardian Date***

**Notice of Privacy Practices**

I have received a copy of Lighthouse Family Center, Ltd., Notice of Privacy Practices, either on paper or have been given access to a copy through the patient portal.

I understand that I can ask any questions that I may have about these policies at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

***Signature of Client / Parent / Guardian Date***