Lumina Counseling Associates PLLC

CLIENT REGISTRATION FORM FILE NO. _____

CLIENT _____ DATE _____

ADDRESS _____

CELL_____ HM _____ WK _____

EMAIL _____

AGE _____ DOB _____ OCCUPATION _____

SCHOOL _____

IF CLIENT IS A MINOR, PARENT NAMES _____

MOTHER CELL _____ FATHER CELL_____

MOTHER EMAIL_____

FATHER EMAIL_____

EMERGENCY CONTACT NAME_____

PHONE_____

INSURANCE INFORMATION

RESPONSIBLE PARTY_____ DOB_____

EMPLOYER_____

INSURANCE COMPANY _____

INSURANCE ID#_____

_____

CLIENT SIGNATURE DATE

_____

RESPONSIBLE PARTY FOR MINOR RELATIONSHIP

Lumina Counseling Associates PLLC

INTAKE INFORMATION FILE NO. _____

CLIENT_____ DOB_____

WHAT WOULD YOU LIKE TO DISCUSS AT THE INTAKE APPOINTMENT? _____

_____

_____

ARE YOU CURRENTLY BEING SEEN BY ANY OTHER MENTAL HEALTH PROFESSIONAL? _____

NAME/PHONE NUMBER:_____

HAVE YOU SEEN A MENTAL HEALTH PROFESSIONAL IN THE PAST? PLEASE LIST YEAR AND FOR WHAT REASON. _____

_____

DO YOU CURRENTLY TAKE PSYCHIATRIC MEDICATION?_____

PRESCRIBING PHYSICIAN NAME/PHONE NUMBER:_____

MEDICATION/DOSAGE:_____

HAVE YOU EVER RECEIVED A MENTAL HEALTH DIAGNOSIS? IF YES, PLEASE EXPLAIN. _____

_____

HAVE YOU EVER BEEN HOSPITALIZED FOR A MENTAL HEALTH CONCERN? IF YES, PLEASE EXPLAIN. _____

_____

HAVE YOU EVER EXPERIENCED SUICIDAL THOUGHTS PAST OR PRESENT? IF YES, PLEASE EXPLAIN. _____

_____

WHAT ARE YOUR GOALS FOR THERAPY? _____

_____

_____

_____

_____

Lumina Counseling Associates PLLC

INFORMATION RELEASE PG 1 OF 2 FILE NO. _____

CLIENT_____ DOB_____

LUMINA COUNSELING IS AUTHORIZED TO RELEASE PROTECTED HEALTH INFORMATION PERTAINING TO THE ABOVE NAMED CLIENT TO THE ENTITIES BELOW.

ENTITY TO RECEIVE INFORMATION (INITIAL EACH THAT IS AUTHORIZED)

_____ PROVIDE INFORMATION TO CLIENT ONLY

_____ PROVIDE INFORMATION TO SPOUSE/PARENTS

_____ PROVIDE INFORMATION TO EMERGENCY CONTACT

_____ PROVIDE INFORMATION TO THE FOLLOWING PERSONS:

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

METHOD OF COMMUNICATIONS (INITIAL EACH THAT IS AUTHORIZED)

_____ LEAVE INFORMATION ON VOICE MAIL

_____ SEND MAIL TO MY HOME ADDRESS

_____ COMMUNICATE VIA EMAIL INCLUDING CLINICAL INFO/ATTACHMENTS

_____ COMMUNICATE NON-CLINICAL INFORMATION VIA TEXT

I UNDERSTAND THAT THE ABOVE LISTED METHODS OF COMMUNICATION ARE NOT GUARENTEED TO BE SECURE AND COULD BREACH THE CONFIDENTIALITY OF MY PERSONAL INFORMATION. LUMINA COUNSELING IS NOT RESPONSIBLE FOR INFORMATION BREACHES ATTRIBUTED TO THE METHOD OF COMMUNICATION.

DESCRIPTION OF INFORMATION TO BE RELEASED (INITIAL EACH THAT IS AUTHORIZED)

_____ FINANCIAL INFORMATION/RECEIPTS/INSURANCE/BILLING

_____ PSYCHOLOGICAL INFORMATION/TREAMENT SUMMARIES

_____ APPOINTMENT REMINDERS/CHANGES/INQUIRIES

INFORMATION RELEASE PG 2 OF 2 FILE NO. _____

CLIENT_____ DOB_____

RIGHTS OF THE PATIENT

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BE SENDING WRITTEN NOTIFICATION. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE IN CASES WHERE THE INFORMATION HAS ALREADY BEEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED AS DESCRIBED IN THIS DOCUMENT. I CAN DO THIS BY WRITTEN NOTIFICATION TO: LUMINA COUNSELING ASSOC. PLLC 610 W. PEACT ST. RALEIGH NC 27605.

I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

_____

SIGNATURE OF CLIENT DATE

_____

PRINT OR TYPE NAME OF CLIENT

_____

SIGNATURE OF RESPONSIBLE PARTY FOR MINOR DATE

_____

PRINT OR TYPE NAME OF RESPONSIBLE PARTY

Lumina Counseling Associates PLLC

CREDIT AUTHORIZATION FILE NO. _____

NAME_____ DOB_____

LUMINA COUNSELING PARTICIPATES IN-NETWORK WITH BLUE CROSS BLUE SHIELD INSURANCE. IF YOU ARE UTILIZING BCBS BENEFITS, LUMINA COUNSELING WILL SUBMIT THE CLAIM FOR PAYMENT. ONCE THE FIRST CLAIM HAS BEEN ADJUDICATED, YOU WILL BE NOTIFIED OF THE PORTION YOU ARE RESPONSIBLE FOR. IF YOU CONTACT BCBS PRIOR TO TREATMENT YOU CAN ACCESS THE SPECIFICS OF YOUR INSURANCE PLAN INCLUDING DEDUCTIBLES AND CO-PAYS FOR OUTPATIENT MENTAL HEALTH BENEFITS.

IF YOU ARE COVERED BY ANOTHER INSURANCE CARRIER, LUMINA COUNSELING CANNOT FILE ANY CLAIMS FOR YOU. YOU MAY REQUEST A DETAILED RECEIPT THAT YOU MAY SUBMIT FOR ANY OUT OF NETWORK REIMBURSEMENT THAT YOUR INSURANCE PLAN MAY PROVIDE YOU.

NON-BCBS CLIENTS: PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE.

MISSED APPOINTMENTS AND/OR CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE WILL RESULT IN A $50 FEE.

LUMINA COUNSELING UTILIZES SQUARE FOR ALL CREDIT CARD PROCESSING. YOU WILL RECEIVE A RECEIPT FOR EACH TRANSACTION VIA EMAIL.

IF YOU REQUIRE A MORE DETAILED RECEIPT FOR INSURANCE AND/OR HEALTH SPENDING REIMBURSEMENT, PLEASE INITIAL HERE. _____ HOW OFTEN? _____

RATE INFORMATION (additional rates available on website www.luminacounseling.com)

INITIAL 60-75 MINS:	$150
INDIVIDUAL 60 MINS:	$110
COUPLE/FAMILY 60 MINS:	$135

CARD NO. **EXP** **CVV** _____

I AUTHORIZE LUMINA COUNSELING TO CHARGE MY CREDIT CARD ON FILE FOR ANY FEES ASSOCIATED WITH THERAPY SERVICES INCLUDING BUT NOT LIMITED TO CO-PAYS, DEDUCTIBLES, STANDARD RATES, CANCELLATIONS, AND MISSED APPOINTMENTS. I CAN REVOKE THIS AGREEMENT AT ANY TIME WITH A WRITTEN STATEMENT INDICATING AN ALTERNATE PAYMENT ARRANGEMENT.

_____

RESPONSIBLE PARTY DATE