Client Registration Form

Date: _____

Client Name: _____ Birth date: _____

Gender: _____ Ethnicity: _____

Email: _____ Religious preference (if any): _____

Phone number(s):

Cell: _____ Home: _____ Work: _____

Occupation/Employer: _____
Preferred contact number: Cell ☐ Home ☐ Work ☐
Check the boxes for the methods you consent to be contacted by:
Phone ☐ Voicemail ☐ Text Messages ☐ E-mail ☐

Street address: _____ City: _____

State: _____ Zip code: _____

Spouse or Partner (if Couples Therapy)

Client Name: _____ Birth date: _____

Gender: _____ Ethnicity: _____

Email: _____ Religious preference (if any): _____

Phone number(s):

Cell: _____ Home: _____ Work: _____

Occupation/Employer: _____
Preferred contact number: Cell ☐ Home ☐ Work ☐
Check the boxes for the methods you consent to be contacted by:
Phone ☐ Voicemail ☐ Text Messages ☐ E-mail ☐

Street address: _____ City: _____

State: _____ Zip code: _____

Parent or Legal Guardian (if Child Therapy)

Name: _____ Birth date: _____

Relationship to child: _____ Responsible Party: Yes ☐ No ☐

Gender: _____ Ethnicity: _____

Email: _____ Religious preference (if any): _____

Phone number(s):

Cell: _____ Home: _____ Work: _____

Occupation/Employer: _____

Preferred contact number: Cell ☐ Home ☐ Work ☐

Check the boxes for the methods you consent to be contacted by:

Phone ☐ Voicemail ☐ Text Messages ☐ E-mail ☐

Street address: _____ City: _____

State: _____ Zip code: _____

Medical Information

Primary Care Physician: _____ Phone: _____

Street address: _____ City: _____

State: _____ Zip code: _____

Is your physician aware of the problems for which you are now seeking services? Yes ☐ No ☐

If yes, please list the extent to which they are aware: _____

Please list any health or medical problems within the last 5 years: _____

_____

Please list any medications, prescribed or otherwise: _____

Do you consent to us coordinating care with your PCP? Yes ☐ No ☐

Emergency Contact

Name: _____ Phone: _____

Relationship to client: _____

Has client had previous therapy/counseling experiences? Yes ☐ No ☐

If yes, please describe: _____

How did you hear about us? _____

Consumer Information and Consent

The following information describes the nature of services provided by Stephanie Weiland, LLC and your rights as a consumer of therapy. If you have any questions about the following information, you should discuss them with your therapist.

Stephanie Weiland, LLC provides mental health services. Our mailing address is P.O. Box 473 Fulton, MD 20759. Our phone number is (301) 490-1011. Stephanie Weiland, LLC serves adults, couples, families, adolescents, and children.

As a therapy consumer, you have the following rights:

1. To know the name, office address, and office phone number of your therapist. This information is listed on the website at drstephanieonline.com and will be provided to you upon request to your therapist.
2. To know the degrees, credentials, and licenses held by your therapist. Please discuss with your therapist if you have questions about their education or licensure.
   Some of the therapists at our practice are licensed as an LGPC or an LGMFT, which means that these therapists are providing counseling services under clinical supervision. In this case, your therapist with an LGPC or LGMFT is responsible to tell you the name and contact information for their clinical supervisor. If your therapist is an LGPC or LGMFT, do you consent to your therapist sharing your clinical information with their clinical supervisor? Yes ☐ No ☐
3. To receive information concerning the methods of therapy employed and the techniques used, the duration of therapy (if known), and the fee structure of services provided. Please discuss with your therapist if you have questions.
4. To seek a second opinion from another therapist.
5. To terminate therapy at any time. However, it is highly recommended that you discuss this decision with your therapist to ensure adequate closure. This in no way restricts your right to end therapy.

Confidentiality: All information provided by you during therapy sessions is legally confidential and may not be released except under certain circumstances.

1. Therapists are required to report any suspected child abuse or neglect and/or elder abuse or neglect to the appropriate social services agency. Further, abuse can be defined as physical abuse, sexual abuse, and/or verbal/mental abuse.
2. If therapists receive information from a client concerning a threat of imminent physical violence, they must notify law enforcement authorities.
3. Therapists will need to break confidentiality if the therapist receives a court subpoena and is ordered to provide testimony or client records.
4. Certain demographic and clinical information must be released to your insurance company (if we are billing your insurance) in order for Stephanie Weiland, LLC to be reimbursed for services rendered.
5. Many couples therapists decide to have an individual session with each partner as a routine part of assessment and/or treatment. In these sessions, the therapist cannot keep information shared confidential from your partner, because that would create a conflict of interest. In these sessions, you should only share information that you are comfortable being discussed within conjoint couples therapy.

Communication with Other Providers

There may be times where another therapist within our office is providing therapy to others in your family or for another purpose, for example one therapist for couples therapy and another therapist for individual therapy. In such a situation, it may be beneficial for treatment for the separate therapists to be able to communicate clinical information about a Client with each other to provide better therapy to their respective Clients. **Do you consent to your therapist sharing your clinical information with other therapists within the practice? Yes ☐ No ☐**

E-mail Policy

Clients must understand that we can never guarantee e-mail information will stay protected and private due to the nature of the internet. Therefore, we ask that clients keep e-mail communications limited to topics such as scheduling or general questions, and refrain from discussing sensitive clinical matters. In the rare event that a therapist may address a question regarding a clinical matter in an e-mail, you acknowledge and agree that by responding to your question, the therapist is intending to accommodate you and that the preferred form of communication for clinical matters is in person, by phone, or by videoconference. Additionally, e-mail is not considered to be an appropriate means of communication for clients in a time of crisis, and we are not set-up as a crisis clinic.

Electronic Communication

In order to make our processes easier and more seamless for our Clients, we offer a secure online portal that enables Clients to see scheduled appointments, cancel and reschedule appointments, and access registration paperwork. Our therapists may in the future be able to send information about your care directly to you through the secure portal as well. This system is different than e-mail and is meant to be used for therapy practices. By registering as a Client, you agree that we may contact you electronically through our secure system.

Videoconferencing

There may be times that it is more convenient for you to communicate with your therapist by videoconferencing, or you and your therapist may agree to exclusively use videoconferencing for your appointments. Our therapists use secure videoconferencing systems for any virtual appointments. As with any form of videoconferencing, we are unable to control any location that is not in our office. You should be mindful of your surroundings during any videoconference therapy session and avoid locations where you and your therapist might be overheard discussing sensitive clinical matters.

Nonprofessional Relationships

Clients should be aware that personal relationships with their therapists are never appropriate and should be reported to the Maryland Department of Health. If you have a grievance against your therapist, please speak to Dr. Stephanie Weiland Knarr or contact the Maryland licensing board for Professional Counselors and Therapists at (410) 764-4732.

If you and your therapist should see each other in a place outside of the therapy office, your therapist will not acknowledge you unless you acknowledge the therapist first. You will need to initiate contact with a smile, wave, or a conversation. This is to protect your privacy.

HIPAA Notice

I acknowledge that my therapist has provided me with a hard copy of the HIPAA notice of the privacy policy for Stephanie Weiland, LLC and that the policy is also available on Stephanie Weiland, LLC's website at drstephanieonline.com. If you have completed registration paperwork through our online portal, we do not typically provide a hard copy of the HIPAA notice. However, if you would like a hard copy, please let your therapist know when you are in our office and we will provide one to you.

Fees

The therapist's fee should be paid prior to each therapy session. Rates can be found on the website at drstephanieonline.com. For more information regarding payment, please review the cancellation policy and financial agreement carefully.

Credit Card Information

Per our financial agreement, all clients must have a credit card on file to hold all appointments. For any appointments not cancelled 24 hours in advance, the cost of the appointment may be charged to any of the credit or banks cards that you have put on file. Also, if you are using health insurance, any deductibles or costs associated with the therapy not covered by health insurance may be charged to any of the credit or banks cards that you have put on file.

Credit Card #: _____ Name on card: _____

Expiration Date: _____ Security code: _____

Billing address: _____

Client's Statement

I consent to mental health treatment by Stephanie Weiland, LLC. I understand the above and indicate my agreement by the following signature.

Signature: _____ Date: _____

Signature: _____ Date: _____

Cancellation Policy

Your credit card on file will be charged if your appointment is not cancelled 24 hours in advance or if a weekend appointment (Friday 5:00 pm – Sunday 9:00 pm) is not cancelled before 5:00 pm on Thursday. The late cancellation fee is not meant to be punitive. Rather, this policy is meant to help provide you with a good service while making sure your therapist has peace of mind to provide you that service. This cancellation policy is a standard practice among all psychotherapists in addition to similar health providers, such as massage therapists. Therapists are different than other medical providers when it comes to late cancellations because they reserve their time with patients for a full hour. This is unlike many medical doctors and providers who schedule much shorter appointments with their patients and overschedule extra patients to help defray the costs of missed appointments. Because many of our clients attend appointments on a weekly or bi-weekly basis, clients understandably do not have time or patience to sit and wait for 30 minutes to 2 hours each week because their therapist has over-scheduled (again, this is what medical doctors do and hence why you often have to wait longer).

In addition, therapists ethically should not over-schedule themselves. For example, if therapists scheduled 50 clients per week to help defray the costs of missed appointments and late cancellations and everyone showed up, then the burnout level for your therapist would likely be too high for your therapist to truly be attentive to your needs. There are only so many relationship problems and/or psychological traumas and problems that your therapist can listen to in a week without having burnout.

For your therapist to do a good job, they need the security of knowing that even if something comes up (e.g., you get called into a work meeting or someone in your family is sick or you were invited to a party or date that you just don't want to miss) that they can still meet their financial obligations and plan money in their budget for rest and vacation. Please think of your therapist as similar to your childcare or other service providers and plan for possible cancellations in your budget. Even if you or your child are sick or there is an emergency, and you do not use the service, you still must pay for it. There other similar service providers who operate comparably.

If your weekend appointment is not cancelled by 5:00 on Thursday and you are not charged a fee, then this likely means that your therapist experiences a loss. Your therapist loses income and they also lose the opportunity to make other personal weekend plans with their loved ones. Most clients schedule weekend therapy appointments by Friday at noon, so late cancellations mean that the therapist is unlikely to fill the spot with another weekend client to defray the costs of the late cancellation or missed appointment. Additionally, therapists can feel disrespected because they have given up time that they could have scheduled plans with their own loved ones in order to be available to accommodate clients who need and seek weekend appointments.

Your financial agreement states that you are responsible for the therapist's standard hourly rate for a missed appointment or late cancellation. If you are a client who uses insurance, the full cost includes not only your usual copay or coinsurance, it also includes the cost of what the insurance would reimburse the therapist if they were to have seen you as a patient. If you do not come to your appointment, the therapist cannot bill the insurance company and therefore will lose that amount of money in their paycheck if you do not pay the late cancellation fee.

Financial Agreement - All Clients
(Self-Pay and Co-Pay)

I agree to pay $_____ per one hour session. Payment is expected at each session, unless I have made prior arrangements with my therapist.

I agree that if I pay for any fee or bill with a credit or debit card, there will be an additional 3.5% service charge and that I must have a card on file in order to hold appointments with my therapist.

I understand that if I request my therapist to write a report outside of a regular session time, I will be billed according to the amount of time the report takes my therapist to write. For example, if the report takes the therapist thirty minutes and their hourly fee is $120, then the report will cost $60. I also understand that if I request my therapist to consult with teachers, principals, other doctors, social workers, attorneys, and/or any other professionals, there will be a charge for the therapist's time required for the consultation. I agree to prepay for this service with cash or a check when it is requested, or I agree for my therapist to charge my card on file at the time of the consultation and/or report writing service.

I understand that all appointments not cancelled 24 hours in advance will be charged at the full rate to my credit or debit card on file including the 3.5% service charge. Although my therapist understands that there will likely be times when I need to cancel an appointment, that the time has still been set aside only for me and I am still responsible for the session fee. I understand that a $30 service charge will be added to all returned checks and the fee will be charged to my card on file. I agree to pay all reasonable collection or legal fees should Stephanie Weiland, LLC need to use an outside collection agency or legal means to collect on this account. Balances older than 30 days may be subject to additional interest charges of 10% per month. The undersigned will be responsible for all costs incurred in the collections of any past due account, including attorney's fees.

I understand and agree with all of the above. Please sign your name below and we will accept your assignment.

Signature: _____ Date: _____

Financial Agreement- Insurance Clients

Primary Insurance: _____ Policy Holder: _____

Employer: _____ Policy Holder's DOB: _____

Phone: _____ Policy/ID#: _____ Group/Plan#: _____

Our office is pleased to accept your insurance assignment. After verification of coverage we will file your claim forms and assist you in every way we can. However, it must be fully understood that the contract is between YOU and your insurance company, and you are fully responsible for any amount not paid by your insurance company. Our office does not guarantee that your insurance company will pay. We will make every attempt to verify your insurance coverage. However, if your insurance claim is for some reason denied, you are responsible for the full amount of the bill. We will not begin a dispute with your insurance company over your claim. That is your responsibility and obligation.

I hereby authorize Stephanie Weiland, LLC to apply for benefits on my behalf for covered services rendered by this office. I request that payments from my insurance be made directly to Stephanie Weiland, LLC. Should an insurance payment inadvertently be sent to me, I will endorse it and return it to Stephanie Weiland, LLC immediately. I understand that the card I have put on file may be charged for any balance unpaid by the insurance company, including deductibles and coinsurance that is unpaid. I certify that the information I have reported with regard to my insurance is accurate. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time by form of written request.

I agree to pay copays and any unmet deductible at the time of my appointment, and I agree to the terms listed above in the financial agreement that applies to all clients, regardless of the use of insurance.

Signature: _____ Date: _____

Electronic Registration Acknowledgement

I acknowledge and agree that I have completed my registration paperwork electronically. By signing below, I agree that all of the information I provided electronically is accurate. I also acknowledge and agree to all terms and conditions of treatment. I further agree that I will not be receiving a hard copy of any documents accessible through the health portal. However, if I would like a copy of the HIPAA policy for Stephanie Weiland, LLC, I may obtain a copy by requesting it in person from my therapist.

Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) REQUIRES THIS NOTICE. PLEASE REVIEW IT CAREFULLY.

You know and trust Stephanie Weiland, LLC. We value your trust. If you have any questions about this notice, please contact Dr. Stephanie Weiland Knarr at 301-490-1011.

Stephanie Weiland, LLC. is required by law to:

- Make sure that health information that individually identifies you is kept private,
- Give you this notice of our legal duties and privacy policy with respect to health information about you, and
- Follow the terms of the notice that are currently in effect.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand the confidential nature of the individually identifiable health information (also called protected health information) you provide to Stephanie Weiland, LLC. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice, whether made by your mental health care provider, or others working in this office. This notice will help you understand how Stephanie Weiland, LLC. may use and disclose certain protected health information you provide us and what rights you have concerning that information. This privacy policy will tell you:

1. What health information is protected,
2. How Stephanie Weiland, LLC may use and disclose your protected health information, and
3. Your rights concerning your protected health information

1. WHAT INFORMATION IS PROTECTED

Health information protected by the privacy policy includes information Stephanie Weiland, LLC. receives or creates that identifies you and concerns:

- Your past, present, or future medical and mental health condition,
- Mental health care that is or has been provided to you, or
- The past, present, or future payment for mental health care provided to you.

2. HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Stephanie Weiland, LLC. may use or disclose your protected health information to provide you with treatment, obtain payment for your treatment, or perform health care operations. The following categories describe different ways that we use and disclose health information. Each category of uses or disclosures includes an explanation and to the extent applicable, contains examples. Not every possible use or disclosure will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. Some examples of how we may use or disclose your protected health information for these reasons are:

- *Treatment*. We may use or disclose your protected health information to provide you with effective mental health treatment, provide you with information and counseling regarding your mental health treatment, and communicate with other staff and health care professionals to ensure that you receive appropriate treatment.
- *Payment*. We may disclose health information about you so that the treatment and services you receive from us may be billed and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your treatment so that your health plan will pay us or reimburse us for services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- *Health Care Options*. We may use your protected health information for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use protected health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective or to compare how we are doing with others to see where we can make improvements. We may remove health information that individually identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

Stephanie Weiland, LLC. may also use or disclose your protected health information for other reasons. These reasons and some examples of how we may use or disclose your protected health information are:

- *Communications with you*. We may use your protected health information to contact you. We may contact you to ensure that your treatment is effective or to provide with reminders regarding appointments. Please let us know if you do not wish us to send you information about possible treatments that may be of interest to you or if you wish to have us use a different address to send this information to you.
- *Law Enforcement*. We may disclose your protected health information as required by law in response to requests from local, state, or national law enforcement including:
  - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
  - Concerning a death we believe has resulted from criminal conduct,
  - Regarding criminal conduct at our offices,
  - In response to a warrant, summons, court order, subpoena or similar legal process,
  - To identify/locate a suspect, material witness, fugitive or missing person,
  - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).
- *Services*. We may hire third parties to perform certain services for us. We may disclose your protected health information to these parties so that they can perform the services that we have asked them to do. These third parties will be required to protect your individually identifiable health information and will not be allowed to use your individually identifiable health information for any other purpose other than to provide the services we requested.

- *Public Health Risks*. We may disclose health information about you for public health activities. These activities generally may include the following:
  - To report child abuse or neglect;
  - To notify the appropriate government authority if we believe a client has been the victim of abuse, neglect, or domestic violence. We will make this disclosure if you agree or when required by law.
  - To notify appropriate government authority if a client threatens to harm themselves or someone else.
- *Health Oversight Activities*. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- *Lawsuits and Disputes*. If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- *Other Circumstances*. We may disclose your protected health information in certain and special circumstances. Such circumstances include disclosures to agencies authorized by law to collect information for national security and intelligence activities, specialized government functions in the event you are a veteran or are in the military, investigation of a death or identification of a deceased person, review of product quality and safety, or to comply with requirements for worker's compensation programs.

The examples given above are for illustration only. They may not be all-inclusive. Stephanie Weiland, LLC. may also use or disclose your protected health information as otherwise required by law. Stephanie Weiland, LLC. will obtain your written authorization before using or disclosing your protected health information for any reason other than those included in this notice. You may revoke your authorization in writing at any time. Upon receipt of your written revocation, we will stop using or disclosing your protected health information, except to the extent that we have already taken action in reliance on the authorization.

3. YOUR RIGHTS

You have certain rights concerning your protected health information and this Notice. These rights include:

- *Notice*. You may request a copy of this Notice or any updated Notice at any time. To request a paper copy, visit Stephanie Weiland, LLC. or send a written request.
- *Inspection and copies*. You have the right to inspect and obtain a copy of the protected health information that may be used to make decisions about you, including session records and billing records. You must submit your request in writing to Stephanie Weiland, LLC, in order to inspect and/or obtain a copy of your protected health information. Stephanie Weiland, LLC may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Stephanie Weiland, LLC may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another professional chosen by us will conduct reviews.

- *Amendment*. If you feel that the protected health information we maintain about you is incomplete or incorrect you may request that we amend it. To request an amendment, contact Stephanie Weiland, LLC. We may request that you submit a written request. The request must include the reasons you are requesting the amendment. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you may send us a written statement disagreeing with our denial.
- *Restrictions on Uses and Disclosures*. You have the right to request additional restrictions on our use or disclosure of your protected health information. Your request must be submitted in writing to Stephanie Weiland, LLC. We are not required to agree to any restrictions you request if it is not feasible for us to ensure our compliance or believe it will negatively influence the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request a restriction, you must make your request in writing to Stephanie Weiland, LLC. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.
- *Accounting of Disclosures*. You have the right to receive an accounting of the disclosures we have made of your protected health information. The accounting will not include disclosure made for treatment, payment or health care operations, disclosures made directly to you, disclosures made to your friends or family members involved in your care, or disclosures authorized by you. The right to receive an accounting of disclosure is subject to certain other exceptions, restrictions, and limitations. To request an account of disclosures, contact Stephanie Weiland, LLC. Stephanie Weiland, LLC may request that you submit your request in writing.
- *Right to Request Confidential Communications*. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. To request confidential communications, you must make your request in writing to Stephanie Weiland, LLC. We will not ask you the reason s for your request. We will accommodate all reasonable requests to the extent that we are able to do so. Your request must specify how or where you wish to be contacted.

ELECTRONIC HEALTH INFORMATION

There may be times that your protected health information may be maintained or accessed electronically. We may use a secure online portal for purposes of collecting and providing access to certain of your protected health information. We take several steps to ensure that your protected health information remains secure including access control such as usernames and passwords, encryption and authentication of your protected health information, and change logs with respect to protected health information. Our intention is to treat all protected health information maintained electronically in the same way as we do with all of your protected health information as set forth in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or would like additional information about the Stephanie Weiland, LLC privacy policy, you may contact Stephanie Weiland, LLC at 301-490-1011. If you believe your privacy rights have been violated, you may file a complaint with Stephanie Weiland, LLC and with the Secretary of Health and Human Services. To file a complaint with Stephanie Weiland, LLC., send your complaint in writing to Dr. Stephanie Weiland Knarr, Stephanie Weiland LLC, P.O. Box Fulton, MD 20759. There will be no retaliation against you for filing a complaint.

REVISIONS TO NOTICE

Stephanie Weiland, LLC. may revise the terms of this Notice and make effective for all of your protected health information. If Stephanie Weiland, LLC. makes a material change to this Notice, a new Notice will be posted by Stephanie Weiland, LLC. staff and will be available to you upon request and at drstephanieonline.com.

EFFECTIVE DATE

This notice is effective as of February 1, 2020 and revises the notice effective August 1, 2009.

Stephanie Weiland, LLC. is required by law to maintain the privacy of your protected health information and to provide you with this Notice. Stephanie Weiland, LLC. is required to comply with the terms of the Notice for so long as it is in effect. We will request that you sign a separate form acknowledging you have received a copy of this Notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgement will be filed with your records.