501 Church St. NE Suite 106
Vienna, VA 22180
(703) 755-0995
jenniferspeedlpc@gmail.com

Registration Form

(Please Print)

Today's Date: ___/___/___

How did you hear about us? ____

Patient's Full Name: ____SS#_______________

Home Address: __________________________ City: ____________ State: ____ Zip: ________ Home Phone: ( )______________ Age: ________ Marital Status: ____________ DOB: ___/___/_____

Cell Phone: ( )_______________ E-mail Address: ________________ ____________________

Would you like to receive Email reminders or Newsletters from the Center? **Yes** **No**

Employer Name: __________________________________ Work Phone: ( )________________

If Student, School or College: _____________________________________

Emergency Contact: ________________ Relationship: ___________ Phone #: ( )____________

INSURED/ RESPONSIBLE PARTY INFORMATION

(Please complete if you are using insurance coverage)

Name of Insured: ____________________________ Relationship: ______________ SS#: ___________
(Last/First/MI)
Home Address: ____
Home Phone: ( ) _______________________ DOB: ____/____/_____
Employer Name: ___________________________________ Employer Phone: ( )_________________
Primary Insurance: ___________________ ID#: __________________ Group #: ___________________
Secondary Insurance: Y N Company: __________________________ Policy #: ___________________

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INDIVIDUAL'S FINANCIAL RESPONSIBILITY

(i) I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
(ii) I understand that SFTS, Inc., will provide benefits information that is given online, however, I am responsible for verifying my benefits with my insurance company before receiving services.
(iii) Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit.
(iv) In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
(v) If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Solution-Focused Therapy Services, LLC., on my behalf for any services furnished to me by the providers.

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Solution-Focused Therapy Services, LLC to release to my insurer all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

BILLING POLICY

- I agree to pay for the medical services rendered to me at time of service.
- I understand that I am responsible for payment of any outstanding debt within 30 days of receiving an invoice to avoid a 10% late charge.
- I understand that there is a $75.00 cancellation fee if appointments are not cancelled within 24 hours.
- I understand that credit/debit card information is stored in our HIPPA compliant management system for payment of services.
- In the event that your account goes to collections, there will be a 25% collection fee added to your balance.
- There will be a $30 service charge on all returned checks.
- Your credit or debit card will be charged $75.00 (not co-pay amount) automatically in the event of a missed appointment with no notification and in the case of a delinquent

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balance (15 days after an account statement requesting amount due has been sent).

I understand and accept all of the terms regarding billing policies.

Signature: ___________________________Date: ____________

CONFIDENTIALITY

We are required to disclose confidential information if any of the following conditions exist:

- You are a danger to yourself or others.
- You voluntarily waive your rights to privilege or give consent to limited disclosure by your therapist.
- You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
- You file suit against your therapist for breach of duty or your therapist files suit against you.
- You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
- Your therapist is appointed by the courts to evaluate you.
- Your contact with your therapist is for the purposed of determining sanity in a criminal proceeding.
- Your contact is for the purpose of establishing competence.
- Your contact is one in which your therapist is required to file a report to a public employer or as information is recorded in a public record and is open to public inspection.
- You are under the age of 16 and are the victim of a crime.
- You are a minor and your therapist reasonably suspects you are a victim of child abuse.
- You are over the age of 65 and your therapist believes you are a victim of physical or emotional abuse.
- You die and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting as interest in property.

** If you have any questions about these limitations, please discuss them with your therapist.

Signature: ____________________________________Date: ____________

I am consenting to my (or my dependents') outpatient treatment.