Family Counseling Associates, LLC

12 Essex Street | Andover, MA 01810
360 Route 101, Suite 12B | Bedford, NH 03110
152 Sylvan Street, Suite 12A | Danvers, MA 01923

NEW CLIENT REGISTRATION FORM

Date:_____ **Date of Birth:**_____

Client Name:_____

Client Address:_____

City:_____ **State:**_____ **Zip:**_____

Best Telephone:_____ **Email:**_____

Parent or Guardian Name:_____
(If Applicable)

Emergency Contact:_____**Relationship:** _____

Emergency Contact's Phone:_____

PCP COMMUNICATION AUTHORIZATION

I would like FCA to inform my Primary Care Physician that I am receiving mental health services:

____YES ____ NO (if NO, skip this section)

Name of PCP or Practice:_____

Address:_____

Phone: _____ Fax: _____

Communication Authorization: I authorize Family Counseling Associates, LLC to disclose and/or obtain information from the above mentioned physician or medical office. The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I understand that I have a right to revoke this authorization, in writing, at any time.

Signature of Client/Guardian:_____

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TREATMENT AGREEMENT

I attest that I have requested mental health services with FCA, LLC. Please check the appropriate selection:

[ ] I will utilize my health insurance for service. I authorize the office of Family Counseling Associates, LLC to bill my health insurance carrier on my behalf.

[ ] I will self-pay for service at a rate of $_____ per session.

_____

Client [or Guardian] Signature

NOTICE OF PRIVACY POLICY

My signature below indicates that the "Notice of Privacy Practices" was available for my review, and is also available at at www.fca-andover.com. I am aware that I can also ask my clinician for a paper copy. I understand that I may ask questions about the information outlined in the Notice at any time in the future.

_____

Client [or Guardian] Signature

COMMUNICATION CONSENT

I give permission to FCA to contact me at the phone number(s) or email listed on this Client Registration Form. If I am not available, I authorize Family Counseling Associates to leave a message on my voicemail. My signature below indicates that I am aware that the "Electronic Communication Policy" is available for my review at www.fca-andover.com. I am aware that I can ask my clinician for a paper copy.

_____

Client [or Guardian] Signature

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Initial Evaluation	$175 per 50-60 minute session
Individual	$140 per 45-50 minute session
Couples and Families	$160 per 50-55 minute session

SERVICES NOT COVERED BY INSURANCE

Written Report or Letter	$75 per page
School Conferences	$200 per hr. (plus travel time)

Telephone / Email Communication:
Telephone and email communication with your clinician is not covered by insurance. There is no charge for brief, routine phone calls or emails (less than 10 minutes) between a client and their clinician to discuss scheduling, billing, or brief progress updates. However, longer correspondences between a client and clinician, as well as all collateral correspondences, will be billed at a rate of $25 per 15 minutes. This fee also applies to all paperwork clinician's complete on behalf of clients. _____(initial)

Cancellations / No-Shows:
A 24-hour advance notice is required for all cancellations. No-shows and late cancellations (less than 24-hour notice) will result in a fee of $70 which is payable before subsequent sessions can be scheduled. *This fee is not covered by insurance.* _____(initial)

Payment Policy:
All session payments and copayments are to be made at the time of each visit. Statements of balance will be sent out at the end of each month. Payment in full is due within 30 days unless an alternate agreement is made in advance. All delinquent accounts will be sent to collections. _____(initial)

Insurance:
Notify us immediately of any changes to your health insurance coverage. It is your responsibility to keep your medical insurance information updated. Clients will be responsible for paying all claims that are not reimbursed by their insurance company due to changes to, or termination, of their policy. Family Counseling Associates, , LLC does not submit secondary insurance claims, or Worker's Compensation claims. _____(initial)

Sliding Scale / Reduced Fee:
We offer a reduced fee schedule. Please contact us for more information. _____(initial)