Registration for Carolina Integrative Psychotherapy

(PLEASE PRINT) Today's Date:_____

Full name: _____ Date of Birth: __ / __ / ____

Home Address: _____ City:_____ State: _____ ____ Zip: _____

Phone: ___ _____ Employer or School (if student): _____

Referred By:_____ Physician: _____

Person to Contact in Emergency: _____ Phone: _____

INSURED/RESPONSIBLE PARTY INFORMATION

Full Name of Insured: _____ Relationship: _____ Date of Birth: __ / __ / ____

Home Address: _____ Phone: _____

City: _____ State: ___ Zip: _____ Employer: _____

Insured's Primary Insurance Co.: _____

I.D. No.: _____ Group No.: _____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions and I authorize the release of information to my insurance company.
2. I have been given information on privacy practices, client rights and responsibilities. Therapy sessions are 45-55 minutes.
3. I authorize direct payment to my service provider, John Mader/CIP.
4. I understand that I am responsible for any deductible amount, co-pay, co-insurance amount or if paying myself, the full amount of my bill for services provided. I understand there will be a $25 service charge on returned checks.
5. I understand there is a 24-hour cancellation policy that I cancel my appointment 24 hours in advance between the hours of 8am to 5pm Monday thru Friday to avoid incurring a session fee.

INFORMED CONSENT

1. I give my authorization and consent to receive outpatient diagnostic and treatment services having discussed the advantages/disadvantages of the recommended treatment.
2. I will address any concerns or grievances with my therapist, John Mader. I understand I may also contact the NCLMFT Board.
3. I understand that while psychotherapy is confidential, there are limits to my rights to confidentiality, such as situations of danger to myself or another, as well as legal mandates from a judge.
4. I understand that my therapist, John Mader, may seek professional direction and support for my treatment by consulting with one of his consultation teams.
5. I understand that in the event of my therapist's death or incapacitation, Anne Mader, LMFT will serve as his Professional Executor to: a) Act on his behalf in making decisions about storing, releasing and/or disposing of my professional records and b) Carry out any activities deemed necessary to properly close the practice.
6. I agree that any audio or video recording of sessions will only occur if there is clear, written and mutual consent.
7. I am choosing to enter psychotherapy treatment and may discontinue at any time.

Signature _____ Date _____

I agree to communications via email/text and understand/accept the risk that they may not be secure.

Signature _____ Date _____

Preferred Email Address: