WATER'S EDGE
PSYCHOTHERAPY & WELLNESS CENTER

47 Maple Street, Suite 303
Burlington VT 05401

REGISTRATION FORM

Client Name: _____ Date of Birth: _____/_____/_____ M/F

Address: _____ Social Security Number: _____-_____-_____

(Street)

Address: _____ Email Address_____

(City/State/Zip)

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Work Phone: (_____)_____-_____ Can we leave a message at any of these numbers? H C W (circle)

Primary Care Physician: _____ Phone number: (_____)_____-_____

Name of Guardian/Parent (if applicable): _____

Emergency contact: _____ Phone: (___) _____ - _____

How did you hear about our practice? _____

FIRST INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Co-pay amount $_____ HSA? yes/no (circle one) High-deductible? yes/no (circle one)

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security #: _____-_____-_____ Policy Holder's Date of Birth: _____/_____/_____

SECOND INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Policy Holder: _____ Co-pay amount $_____ Group Number: _____

Policy Holder's Social Security #: _____-_____-_____ Policy Holder's Date of Birth: _____/_____/_____

PERSON RESPONSIBLE FOR BILL

Guarantor Name: _____ Date of Birth: _____/_____/_____

Relationship to Client: (check one): ( ) self, ( ) spouse, or ( ) parent/guardian Phone Number: (___) _____

Address (if different from client): _____

(Street) (City/State/Zip)

Signature: _____

PERSON(S) WHO HAVE LEGAL CUSTODY

Name(s)_____

Signature: _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Water's Edge Psychotherapy. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____/_____/_____

Therapist_____ DX:_____ 1st Date of Service: _____/_____/_____

WATER'S EDGE
PSYCHOTHERAPY & WELLNESS CENTER

47 Maple Street, Suite 303
Burlington VT 05401

Adult Intake

Client Name: _____ Date of Birth: _____/_____/_____

Relationship Status: ( ) Single ( ) Married ( ) Civil Union ( ) Divorced ( ) Domestic Partner ( ) Other

Occupation:_____ Education:_____ Religion:_____

Are you a veteran? ( ) yes ( ) no Dates of service_____ Are you retired? ( ) yes ( ) no

Are you a full-time student? ( ) yes ( ) no School:_____

Members in present Household	Relationship to you	Age	Sex	Occupation

Other family members	Relationship to you	Age	Sex	Occupation	Location

Have you **or** someone significant in your life had any problems with the following areas?

	Who? (*i.e. Self*)	When?
Marital		
Relationship		
Family		
Children		
Employment		
School		
Financial		
Legal		
Death		
Pregnancy/miscarriage		
Abortion		
Physical/sexual abuse		
Changes in living situation		
Experiences you cannot explain		
Feelings difficult to handle		
Alcohol/drugs		
Depression/anxiety		
Trauma		
Eating disorder		

What is your primary care physician's name? _____

When was your last physical? _____ Where?_____

Client Name: _____ Date of Birth: _____/_____/_____

Presenting problem_____
_____
_____

History of presenting problem _____
_____
_____

Reasons for seeking therapy now?_____
_____
_____

What are your strengths/supports for handling this problem?_____
_____
_____

Current suicidal thoughts ( ) yes ( ) no plan ( ) yes ( ) no attempts ( ) yes ( ) no self harm ( ) yes ( ) no
History of suicide attempts or self harm _____
Explain_____

Previous Therapy: Include outpatient treatment, psychiatric hospitalization, dates, therapist names, and reasons
_____
_____
_____

Significant Medical Information: List any major medical problems, indicting hospitalization and dates of treatment
_____
_____

Current health problems_____

Medication (over the counter/prescribed)	Dosage	Reason	Effect	MD

Allergies current/past_____ Drug allergies_____
Tobacco use: _____ How much:_____ How often:_____
Caffeine intake _____ How much:_____ How often:_____
Alcohol use:_____ How much:_____ How often:_____
Drug use:_____ How much:_____ How often:_____
Does someone significant in your life drink/use drugs? What _____
How much:_____ How often: _____

Client Name: _____ Date of Birth: _____/_____/_____

Family and Social History

Members in house you grew up in	Relationship to you	Age	Occupation	Location

Where did you grow up? _____

Has any member of your family had a serious medical problem?

Family Member	Problem

Has any member of your family had a serious emotional problem?

	Family Member	Problem
Depression		
Anxiety		
Anger, violence, legal		
Physical, sexual abuse		
Substance abuse		
Suicide		
Divorce		
Other problems		

Difficulties in your family growing up _____

_____

Key events or longer term experiences that have had a significant impact on your life_____

_____

_____

Current relationship with family members_____

_____

Emergency Contact Information

Name_____ Relationship_____

Address_____ City_____ State_____ Zip_____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____ Work (_____)_____-_____

Welcome to Water's Edge Psychotherapy & Wellness Center

This information described below is offered to anticipate the most frequently asked questions about our professional services and business practice. Pleaser read carefully. If you have questions, it is important that you clarify them with your therapist prior to signing.

Appointment & Fees: Therapy sessions are 50-60 minutes. This time is set aside specifically for you. In the event that you must cancel your appointment, please call your therapist at least 24 hours in advance. Failure to give adequate notice will result in you being billed our full appointment fee of $135 (excluding Medicaid covered clients). Insurance companies can not be billed, nor will they reimburse for this cost.

PLEASE NOTE THE FOLLOWING LIST OF OUR PROFESSIONAL FEES
1st Session $150, Follow-up Sessions $135; Group Sessions-$60

Miscellaneous Service Charges: Please be advised that therapists time spent on client-related professional services outside of the therapy session are not billable to insurance. These services include, but are not limited to report others exceeding 15 minutes; face to face consultations with others such as attending school IEP meetings (exceeding 15 minutes), etc. Utilizing the above rates as a guide, this time is billed directly to the client and is pro-rated in quarter hour units (with the minimum of 15 minutes) charged at the quarter hour rate. *This excludes time spent writing customary treatment plans or other similarly related paperwork required by insurance.*

Confidentiality: Privacy and confidentiality are important to the relationship between client and therapists. There is legal and ethical protection for the information that you share with your therapist and it cannot be released without your express written consent. This also covers our written record. There are also expectations to privacy/confidentiality which may include, but are not limited to: when Water's Edge clinicians provide collegial case coverage and case consultation; when there is reason to believe that you intend to harm yourself or another person; when a child, elder or disabled adult has been or might be abused or neglected; or if information has been requested by court order. Additionally, in the even that your therapist is unavailable, a colleague will be covering. If you have any questions about confidentiality, please raise them with your therapist.

Confidentiality and Insurance Companies: If you will be using benefits under a managed care plan including Medicaid, Water's Edge Psychotherapy may be required to provide information related to your case to the managed care reviewer and your primary care physician, in writing and verbally. Water's Edge will follow these procedures unless otherwise notified by you in writing.

If your insurance coverage changes, you are responsible for notifying Water's Edge of the change.
You are ultimately responsible for fees not covered by insurance.

Consent for Treatment: I voluntarily consent to clinical evaluation/treatment for myself or my minor child. I understand that there are both benefits and risks involved with engaging in psychotherapy that there are no guarantees about the outcome.

My signature below indicates that I have had the opportunity to ask and have my questions answered about the above information and I have read, understand and agree to abide by all of the about outlined terms.

Signature _____ _____ Date_____
Print Name of Client Client Signature

Signature _____ _____ Date_____
Print Name of Client Client Signature

Witness Signature _____ _____ Date_____
Print Name of Client Client Signature