WATER'S EDGE
PSYCHOTHERAPY & WELLNESS CENTER

47 Maple Street, Suite 330
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: ______/______/______

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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