Davis Massage & Wellness
Susan Davis, LMT, MSW, RRM
168 Battery Street, Burlington, VT 05401
802-373-3420 * davismassageandwellness.com

CLIENT REGISTRATION FORM

Name: _____ **Today's Date:** _____

Date of Birth:_____ **Referred by:** _____

Preferred Pronoun(s): _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Email: _____ **Okay to email you here?** Yes No

Phone#: _____ **Okay to CALL you here?** Yes No

Okay to TEXT you there? Yes No

BILLING INFORMATION

Name of Subscriber: _____

If *the client and the Subscriber* ***are not the same person****:*

Relationship to the Subscriber: _____ **Their date of birth:** _____

Their address: _____

Name of Insurance Co. _____ **Phone#:** _____

Claims Address: _____

I.D./Policy#: _____ **Group#:** _____

Co-Pay Amount: $ _____ **Deductible:** Met Not Met

I authorize the release of any medical information necessary to process this claim.
Signature: _____ **Date:** _____

I authorize payment of my medical benefits for services provided.
Signature: _____ **Date:** _____

Credit Card Information (for payment of fees):

Credit Card Type Visa / Master Card / Discovery *(please circle one)*

Credit Card Number _____ **Name on Card** _____

Expiration Date _____ **Security Code (CVV)** _____ **ZIP Code** _____

Signature of Cardholder _____ **Date** _____

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Current Medications, over the counter medicines taken regularly, and supplements:

_____

_____

_____

EMERGENCY CONTACT

First and last name: _____ Relationship: _____

Best contact phone number: _____

POLICIES

Contact information: Please contact me by phone or text for scheduling appointments and cancellations. I make every effort to respond within 24 hours, except for weekends, or holidays. Since email is not fully confidential, my preferred way to communicate is through telephone calls.

Missed and canceled appointments: Inclement weather, sudden injury or illness, and emergencies come up occasionally. These situations may provide exceptions to the following:

1. If you need to cancel an appointment, I require a **minimum** of 24 hours' notice (by phone or text ONLY) so that I can schedule other people waiting for appointments.
2. You will be charged the full price of your appointment if the cancellation is received with less than 24 hours' notice. These fees are your responsibility, are permitted by your insurance policy, and are *not* billable to your insurance policy.
3. All billed fees must be paid in-full prior to (or at the beginning of) your next appointment.
4. Insurance company policy also requires supporting documentation related to the incident (the missed/canceled appointment) to be noted in your records.

"I understand that most third-party payment sources, such as insurance companies, do not pay for missed sessions and thus I am solely responsible for the full price. I understand the fees are subject to change. These fees are my responsibility, are permitted by my insurance policy, although not billable to my insurance policy."

By signing here, you agree to the aforementioned policies and understanding:

Signature: _____ **Date:** _____

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Late arrivals: If you arrive late to your appointment, please note that we must still end on-time with respect to the next client, and the full fee for your scheduled session will be due.

Rates: I spend 10 minutes documenting and planning our appointment, and 50 minutes in session with you. Insurance plans vary in what they pay me. Depending on your plan, either full or co-payment is expected at the beginning of each session. If any changes happen to my fees, you will be notified.

Insurance coverage: Co-pays and out of pocket expenses are your responsibility and due at each appointment. I accept cash, credit cards, Zelle, and local checks. There is a $35 fee for any checks returned unpaid. If you have a Managed Care plan, you are responsible for getting the required authorization for mental health services. Coverage for my services will fall under "Supervised Practice". You are responsible for notifying me of any changes in your coverage and/or if you have met your deductible. Insurance can be billed for psychotherapy only and does not apply to any other service I provide.

Privacy of Records and Information Release for Billing Purposes:

"I acknowledge the use of a billing platform (*My Clients Plus*) for billing those charges to my insurance company, and that all claims are submitted electronically."

If necessary, I authorize Susan Davis to contact my insurance company to check on the claims submitted for payment of services.

Signature: _____ **Date:** _____

Assignment and Release: I am currently working toward my Master's level licensure and am supervised by Gordon Petersen, MSW, LICSW, CEAP at Workplace Solutions. To bill your insurance for appointments with me, please read and sign below:

I hereby authorize my insurance benefits to be paid directly to Gordon Petersen, MSW, LICSW, CEAP for my sessions with Susan Davis, LMT, MSW, RRM, and acknowledge that I am financially responsible to Susan for any unpaid balance and fees. I also authorize the release of information needed to verify the medical necessity for my evaluation and treatment to my insurance.

Signature: _____ **Date:** _____

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CLIENT'S RIGHTS AND RESPONSIBILITIES

Client's Rights – You have the right to:

- be treated with dignity and respect.
- fair treatment regardless of race, religion, gender, ethnicity, sexuality, age, disability, or source of payment.
- privacy and confidentiality.
- timely care.
- know about treatment choices.
- participate in developing a plan of care.
- ask your insurance company for information about your insurance coverage, their role in your treatment, and guidelines to which they subscribe.
- ask about my work history, training, and request a printed copy of those.
- know about community resources and services.
- freely file a complaint or an appeal (see my Disclosure document).

Client's Responsibilities -- You have the responsibility to:

- be respectful of the space and others you may encounter while visiting my practice.
- supply information that is needed so that I may provide you with the best care.
- ask questions about our work together.
- actively engage in your own process of growth and development.
- tell me about any updates or changes in your medication or health.
- provide me with updates or changes in your insurance coverage, address, and contact information.
- keep your appointments and give me a minimum of 24 hours' notice if you need to change or cancel.

My signature below shows I have been informed of my rights and responsibilities, and that I understand this information.

Signature _____ Date_____

Print name _____

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CLIENT'S INFORMED CONSENT

- I have chosen to receive treatment services with Susan Davis, LMT, MSW, RRM. My choice has been voluntary, and I understand I may terminate at any time.
- I understand that there is no assurance that I will feel better, and that psychotherapy is a cooperative effort between myself and my therapist. I will actively work with my therapist to resolve my issues.
- I understand that during my course of treatment, we may explore issues which may be upsetting in nature and that this may be necessary to help me resolve my problems.
- I understand that confidentiality of records of information collected about me will be held or released in accordance with state and local laws regarding confidentiality with such records and information.
- I understand that state and local laws require my therapist to report all cases of abuse, neglect of minors or the elderly, as well as all cases in which there exists a danger to self or others.
- I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
- I understand that my therapist may disclose any and all records pertaining to my treatment for the purposes of billing/claims processing, supervision and case management, or coordination of treatment.
- I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered, or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will automatically expire one year after all claims for treatment have been paid.

Client signature _____Date _____

Print name _____

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CONSENT TO TELEMEDICINE SERVICES

Telemedicine involves the use of video and audio communication technology to conduct your therapy session at a distance. If you are unable to travel to my office for your appointment it is possible for us to connect online through a secure video conferencing connection.

If you use insurance benefits to pay for our sessions, please verify with your insurance provider that telemedicine services are covered under your plan. If your plan changes, these benefits might change as well.

Devices and Internet Connection - You can access your telemedicine session with a computer, tablet, or cell phone. Our video and audio feed will work best if your device is connected to a reliable highspeed internet connection.

Security - I always use a secure connection and special video conferencing technology that complies with federal health privacy laws. Before we meet for the first time, I will send you an email link to connect to our session. In the State of Vermont, it is against state law for either the therapist or the client to make a recording of a telemedicine session. All other laws and regulations which apply to in-person therapy sessions will also apply to any sessions conducted online.

Benefits - The benefits of telemedicine include, but are not limited to:

- improved access to care,
- better continuity of care, and
- reduction of lost work time and travel costs.

Risks - Possible risks include *(If any of these happen, either one of us may choose to stop the session at any time.*):

- technical difficulties such as interruptions and unauthorized access.
- our video or audio connection may not work, or it may stop working during our appointment.
- our video or audio quality may not be clear enough for us to communicate effectively.

Special Risks - Special risks are defined as "factors that could impact your quality of care" and include:

- I may miss gestures, cues, or other important non-verbal information during your session.
- If you are in crisis, I may not be able to intervene as effectively as I could in person.
- If you need immediate crisis support, I might not be familiar with the resources available to you in your location.

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By signing this form, you agree to the following:

1. You have read this form and fully understand its contents including the risks and benefits of telemedicine services.
2. You have had a conversation with me during which you had the opportunity to ask questions regarding telemedicine services. Your questions have been answered and the risks, benefits and alternatives have been discussed with you in a language in which you understand.
3. You understand that you have the right to withhold or withdraw your consent to the use of telemedicine in the course of your care at any time, without affecting your right to future care or treatment. You may revoke your consent orally or in writing at any time by contacting me directly.
4. You understand that the laws that protect the confidentiality of your treatment also apply to telemedicine services.
5. You understand that it is illegal in the State of Vermont for you to make a recording of any kind of your telemedicine session(s).
6. You understand that you have a right to a copy of this form and have been offered a copy of this form. You can request that one be sent to you.

Patient Consent to The Use of Telemedicine - I have read and understand the information provided above and have discussed it with Susan Davis, LMT, MSW, RRM. All of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my mental health care and authorize Susan Davis, LMT, MSW, RRM to use telemedicine during my mental health diagnosis, assessment, and treatment.

Client Signature _____ Date _____

Print name _____Date_____

You have a right to a copy of this document. Please keep a copy for your records. For more information about this and other rights, please see the applicable Notice of Privacy Practices.

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I understand the importance of privacy and am committed to maintaining the confidentiality of your medical information. I use the information from your records to provide (or enable other health care providers to provide) quality care, to obtain payment for services provided to you as allowed by your health plan, and to enable me to meet my professional and legal obligations to operate my practice properly. I am required by law to maintain the privacy of protected health information, and to provide individuals with notice of my legal duties and privacy practices with respect to protected health information. I am obligated to notify affected individuals following a breach of unsecured protected health information.

How I May Use or Disclose Your Health Information

I collect health information about you and store it in a chart within a locked area. This chart is the property of my practice, but the information in your chart belongs to you. The law permits me to use or disclose your health information for the following purposes:

1. **Treatment:** I use medical information about you to provide your care. I disclose medical information to others who are involved in providing the care you need, but never without your written consent.
2. **Payment:** I use and disclose medical information about you to obtain payment for the services I provide. For example, I give your health insurance provider the information it requires before it pays me, sharing the minimum amount of information they need to make their assessment.
3. **Health Care Operations:** I may use and disclose this information to review and improve the quality of care I provide for supervision purposes within a secure setting. I may use and disclose this information to get your health plan to authorize services or referrals. I may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs.
4. **Required by Law:** As a mandated reporter, the law requires me to report abuse, neglect, or domestic violence, or respond to judicial or administrative proceedings. This includes suspected elder or dependent adult abuse or domestic violence. I will inform you (or your personal representative) promptly unless in my best professional judgment, I believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

By signing this document, I am signifying that I have received and understand my rights as they pertain to confidentiality of my personal information.

Signature _____ Date _____

Print name _____

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TREATMENT COLLABORATION INFORMATION RELEASE AUTHORIZATION

I, Name of patient (please print) _____
whose Date of Birth is _____ , authorize Susan Davis, LMT, MSW, RRM to share treatment information with: (Name/Title of Person and Organization)
_____ for the purposes of coordinating treatment services by sharing information relevant to treatment and assessment. Confidential collaboration ideally improves treatment planning and outcome.

Patient/Client should initial each item to be disclosed

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Psychotherapy Notes*
*(*Cannot be combined with any other disclosure)*
_____ Other _____
_____ Other _____

Marketing/ Sale of Information -- None of the information within this authorization form will be used for marketing, research, or sold.
Revocation -- I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Susan Davis, LMT, MSW, RRM, otherwise it will expire on the following date: _____or as otherwise indicated.
Conditions -- I further understand that Susan Davis, LMT, MSW, RRM. will not condition my treatment on whether I give authorization for the requested disclosure.
Form of Disclosure -- Unless a specific request in writing has been submitted to Susan Davis requesting that the disclosure be made in a certain format, this authorization allows the disclosure of information in any manner deemed to be appropriate and consistent with confidentiality, applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient, and the protected health information may no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records upon request.

Client Signature _____ Date _____

Print name _____

Signature of Susan Davis, LMT, MSW, RRM_____ Date _____