Safe Harbor Counseling
76 S Main St., Suite A
Sugar Grove, Il 60554

REGISTRATION FORM

(Please Print)

Today's date:_____	Primary Care Physician: _____

PATIENT INFORMATION

Client's **Last Name**: **First:** **Middle**: _____	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) ☐ Single / ☐ Mar / ☐ Div / ☐ Sep / ☐ Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name? _____	Social Security no.: _____	**Birth date:** ___/___/___	Age: ____	Sex: ❑ M ❑ F
Street address: _____		E-mail Address: _____		Home phone #: (___) _____	
City: _____	State: _____	ZIP Code: _____		Cell phone #: (____)_____	
Occupation: _____	Employer: _____			Work phone #: (___) _____	

INSURANCE INFORMATION

INSURANCE CARD & STATE ID REQUIRED

Is this patient covered by insurance? ❑ Yes ❑ No ❑ Self-Pay

Primary Insurance Company:	_____				
Subscriber's Name: _____	**Subscriber's S.S. no.:** _____	**Birth date:** ___/___/___	**Group #:** _____	Identification # _____	Co-payment: $ _____

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable): _____	Subscriber's name: _____	Group #: _____	Identification #: _____	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Send Billing to _____	**Relationship**	**Address** _____	**Contact Phone #** (____)_____

IN CASE OF EMERGENCY

Name of local friend or relative: _____	Relationship to patient: _____	Home phone #: (___)_____	Cell/Work phone # (___) _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Safe Harbor Counseling. I understand that I am financially responsible for any balance not paid by insurance. I also authorize Safe Harbor Counseling, or insurance company to release any information required to process my claims.

_____ _____

Patient/signature *Date* *Guardian signature* *(patient 12-17)* *Date*

Please initial to allow electronic communication: ___e-mail ___cell phone ___home phone __ a message may be left

How did you hear about Safe Harbor Counseling?	❑ Dr.	❑ Insurance Plan	❑ Hospital ❑ Family ❑ Friend ❑ Website/Internet

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FINANCIAL TERMS OF TREATMENT

1. A $75 fee will be charged if an appointment is not kept or notice of cancellation is made with less than 24 hours. A key to successful treatment is commitment to the process. In case of an emergency, death in the family, hospitalization, illness, etc., please speak with your therapist regarding this fee.
2. The undersigned agrees to pay Safe Harbor Counseling in accordance with the regular fees and terms as outlined for the services to be provided to the patient
3. Any insurance claim submitted to an insurance carrier that is denied due to a billing error will be corrected and resubmitted at the expense of Safe Harbor Counseling. Any insurance claim denied due to a patient/guarantor error (incorrect policy information, etc.) will be subject to a claim denial fee in the amount of $5.00 per claim. **Please be aware that Safe Harbor counseling and its agents cannot negotiate with your insurance carrier on your behalf.**
4. Should the account be referred to an agency or attorney for collection, the undersigned will pay for all attorney fees and will be responsible for all collection expenses. The undersigned shall also be held responsible for all interest after 60 days, at the rate of 1.5% of the unpaid monthly balance.
5. The undersigned acknowledges and give permission to the disclosure of their identity and other necessary information relating to the services rendered to the patient by the attending counselor, clinic, or attorney for the purpose of enforcing the patient's or guarantor's obligations to the attending counselor or collection agency or attorney. Such disclosure or re-disclosure shall not be deemed to be a breach of the patient's confidentiality by the attending counselor/psychotherapist or clinic.
6. **The undersigned is responsible for payment in full (cash, check, credit card) due upon receipt of statement.**

I have read and understand the above information and agree to these conditions.

X_____

Signature of patient or responsible party/guarantor Date

AUTHORIZATION AND RELEASE

- I authorize Safe Harbor Counseling to release any information including the diagnosis and the records of any treatment of examination required to the above named patient during the period of such care to the third party payor for the sole purpose of obtaining payment for services rendered to the patient by my therapist Beth Plachetka LCSW, EdD of Safe Harbor Counseling.

- I authorize and request that my insurance company pay directly to Safe Harbor Counseling all insurance benefits otherwise payable to me. **I understand that if benefits inadvertently are paid to me, I am responsible to pay that same amount to Safe Harbor Counseling. Missed appointments are not covered by insurance benefits.**

- I understand that my insurance carrier may pay less than the actual fee for service billed. I agree to be responsible for all fees for service not paid by my insurance carrier for services rendered on behalf or myself, or my dependents, unless prohibited by contract. Choose one below

☐ **OPTION 1.** I want the **D. services** listed above. I want Insurance billed. I understand that I am responsible for payment for any portion of the fees that insurance does not pay. Insurance benefits will be paid directly to Safe Harbor counseling. I understand that if the benefits are sent to me, I must forward that amount to Safe Harbor Counseling.

☐ **OPTION 2.** I want the **D. services** listed above, but do not bill insurance. Payment is expected at the time of service. **I understand that I cannot submit to insurance.** .

Additional Information: Payment for amounts that are patient responsibility: deductible, co-insurance or co-pay is due is due within 10 days of receiving the statement. In the case of financial difficulties, please speak to your therapist.

X_____

Signature of patient or responsible party/guarantor Date