Patient Registration Form

VENTURE COUNSELING GROUP

Patient Information

Full Name: _____ Date of Birth: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Marital Status: _____ Employment Status.: _____ Gender Identity: _____

Employer: _____

Are you insured through your employer? YES ☐ NO ☐ Does your employer offer an EAP program.? YES ☐ NO ☐

Do you know your deductible and copay? YES ☐ NO ☐ If yes, what? _____

Are you the responsible party for billing? YES ☐ NO ☐

If not, please provide their name and address: _____

Insurance Information

Primary Insurance Carrier: Group _____ ID Number: _____

Number _____ _____

Employer Name: _____ _____

Secondary Insurance Carrier: _____ ID Number: _____

Group Number: _____

Employer Name: _____ _____

Preferred Billing

USE OF INSURANCE: *I hereby authorize release of information to file a claim with my insurance company and assign benefits otherwise payable to me, to the office indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. I authorize release of my medical information from this office to other health care providers and/or those listed below. A copy of this signature is as valid as the original. _____initials*

OPT OUT OF INSURANCE:*I am hereby directing Venture Counseling Group to refrain from billing my insurance company for any services rendered. I understand that by prohibiting Venture Counseling Group from filing a claim*

with my insurance company, and that I am solely financially responsible for any services rendered.
_____initials

SELF PAY: *I understand I am responsible for any services rendered by Venture Counseling Group. I authorize release of information to other health care providers and/or those listed below. A copy of this signature is as valid as the original. I understand that I am responsible for all charges for services rendered. _____ initials*

Full Name: _____ Relationship: _____

Purpose: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Purpose: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Purpose: _____ Phone: _____

Address: _____

Consent

Assignment and Release/Consent to Treat

I certify that I and /or my dependents have insurance with the above listed carriers and assign Venture Counseling, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I authorize the use of my signature on all insurance submissions. Venture Counseling may use my health care information and may disclose such information to the above name insurance company(ies) and their agents for the purpose of obtaining payment for service and determining benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I voluntarily and willingly agree to evaluation and treatment. I may withdraw this consent and discontinue the evaluation and treatment at any time.

I understand that information about my treatment and communications with my therapist may not be released without my written authorization. However, these communications or this information may have to be revealed without my permission, as explained below:

- If necessary to protect my safety or the safety of others.
- If I am clearly dangerous to myself, my therapist may take steps to seek involuntary hospitalization and may also contact members of my family or others.
- If I threaten to kill or seriously hurt someone and the therapist believes I may carry out my threat, or if the therapist believes I will attempt to kill or seriously hurt someone, my therapist will notify the proper authorities/personnel.
- If necessary for me to be hospitalized for psychiatric care.
- If a judge thinks the therapist has evidence about my ability to provide care or custody in a child custody or adoption case.
- In court proceedings involving the care and protection of children or to dispense with the need for parental consent to adoption.
- If the therapist believes a child, a disabled person, or an elderly person in my care is suffering abuse or neglect.
- In a legal proceeding where I introduce my mental or emotional condition.
- If I bring an action against the therapist and disclosure is necessary or relevant to a defense.

Attorney Fees and Court Costs

In the event that I fail to pay for all charges for services rendered, Venture Counseling, LLC and its agents shall have all rights and remedies, available in law or in equity, to institute legal action to recover any and all outstanding fees. I agree that all expenses incurred by Venture Counseling, LLC in connection with any such actions or proceedings, including, but not limited to, attorney fees, court costs, and other fees and expenses and all damages, liquidated or otherwise, together with interest thereon at the rate of fifteen (15%) percent per annum until paid.

By signing below, patient indicates that they have reviewed this form, understands it and agrees to the terms.

Signature: _____ Date: _____

Printed Name: _____ _____

Relationship to Patient: _____ _____

Witness: _____ Date: _____