WRIGHT RESOLUTIONS, LLC

Client Registration Form

Section I: Client Information

Date_____

Name:_____ I Prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
You may leave a message on voicemail at: ☐Phone ☐Work ☐Cell
You may leave a message with a person at: ☐Phone ☐Work ☐Cell
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Email Address (only if permissible to contact via email):
_____
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Phone_____
You may leave a message: ☐ on voicemail ☐ with a person
Spouse or Parent's Name:_____ Employer_____ Phone_____
You may leave a message: ☐ on voicemail ☐ with a person
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____

Section II Responsible Party

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Client: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (___)_____
Employer_____ Work Phone (___)_____ SSN#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Client_____
SSN#:_____ Name of Employer:_____ Work Phone: (___)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Client _____
SSN#:_____ Name of Employer:_____ Work Phone: (___)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

_____ _____

Client / Guardian Signature Date

Client Informed Consent

This form acknowledges that you are voluntarily participating, or consenting for your child to participate, in therapy services with also here after referred to as "this provider". Your relationship with Melissa D. Wright, MA, LPC of Wright Resolutions, LLC is strictly professional and it is requested that you do not offer invitations to social events or social media. All information discussed within the context of the therapeutic relationship will be kept confidential. Melissa D. Wright, MA, LPC of Wright Resolutions, LLC can neither confirm nor deny any person as a client without written consent to do so. Under certain circumstances, Melissa D. Wright, MA, LPC of Wright Resolutions, LLC is obligated to break confidentiality and these circumstances are as follows: it is determined that you are a danger to yourself or others; there is suspicion that a child, in or out of your care, is being abused or neglected; record disclosure is ordered by a court/judge; and to obtain payment from your insurance company.
Melissa D. Wright, MA, LPC of Wright Resolutions, LLC may discuss your case from time to time in supervision. While names and other identifying information are not used, you need to be aware of the fact that this provider participates in peer supervision and your case may be reviewed. By signing this form you are consenting to your case being reviewed in supervision.

Sessions are approximately 45 minutes. Initial session is approximately 50-60 minutes. Please note that while it is impossible to guarantee any specific results regarding your treatment goals, therapy will help you identify your specific struggles.

Client Initial_____

If you are in the midst of any type of legal issue such as litigation, a dispute with your employer, separation or divorce, please inform this provider immediately. Please be aware that in custody cases, signed permission from both parents is typically needed, and that medical records are frequently subpoenaed when litigation is involved.

Client Initial_____

All payment is due at the time of service. Cash, personal checks, debit cards, Visa, Master Card, Discover, and American Express cards are acceptable for payment. There is a $25.00 service charge for all returned checks. It is your responsibility to check with your insurance company to determine if your coverage honors outpatient counseling provided by Melissa D. Wright, MA, LPC of Wright Resolutions, LLC Please note that many insurance companies require audits that request information about symptoms, diagnosis, and treatment. By using insurance you are granting permission to communicate confidential information to your insurance company. Please remember Melissa D. Wright, MA, LPC of Wright Resolutions, LLC has no control of, or responsibility for how information is handled once it is released to third parties. If you are using your insurance, and that insurance provider changes, or your co-pay changes, please inform this provider as soon as possible. By signing this form you acknowledge that you will be billed for unpaid session not

covered by your insurance. By signing this form you acknowledge that an outside billing service will be used to submit all insurance claims and you give permission for the least amount of information necessary be given to collect the balance.

Client Initial_____

In the event that you will not be able to keep an appointment for any reason, Melissa D. Wright, MA, LPC requires at least a 24 hour notice. If such advance notice is not received, you will be responsible for paying a $60.00 cancellation fee (not covered by insurance).

Client Initial_____

Melissa Wright MA, LPC of Wright Resolutions, LLC provides outpatient services. Melissa D. Wright, MA, LPC cannot assume responsibility for client's day to day functioning, as some more intensive treatments are designed to do. It is the responsibility of the client to discuss expectations of after-hours care with this provider upon intake so that, if necessary, an appropriate referral can be made. In the case of an emergency, when a client fears harm to him/herself or another, please dial 911or go to your nearest emergency room, as Wright Resolutions, LLC is not an emergency services facility.

Client Initial_____

In situations where there is a physical health emergency and/or there is reason to believe danger to self or others, the following individuals are listed as emergencies contacts whom this provider is authorized to contact:

Contact 1:

Best phone # to reach contact :

_____

Contact 2:

Best phone# to reach contact :

_____

Client Initial_____

My signature below indicates that I understand these policies and I grant consent for Melissa D. Wright, MA, LPC of Wright Resolutions, LLC **to provide psychological services and counseling to myself and/or minor members of my family. I also acknowledge that I have been given a copy of the Client Rights and Responsibilities and HIPPA Privacy Law forms.**

My signature also indicates that I have received information with which I can express any dissatisfaction.

Client/Guardian Signature _____ Date _____

Client/Guardian Signature _____ Date _____

Therapist _____Date _____

To Parents of Teenagers

I understand the need for confidentiality between my teenager and his/her therapist and that confidentiality will be maintained unless the therapist determines that my teenager is a danger to self or others.

Client/Guardian Signature _____ Date _____

Insurance Assignment

I, the undersigned, have insurance coverage with _____ and assign directly to Melissa D. Wright, MA, LPC of Wright Resolutions, LLC all medical benefits. If my insurance company does not cover for any reason, I agree that I am financially responsible for all charges. I also hereby authorize Melissa D. Wright, MA, LPC of Wright Resolutions, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that all services provided outside of my therapy session, which are not covered by insurance, will be billed separately.

Client/Guardian Signature _____ Date _____

HIPAA PRIVACY POLICY

Name:_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Melissa D. Wright, MA, LPC is committed to protecting your information. You have the right to inspect and receive a copy of your records.

All responses to requests for Protected Health Information (PHI) will be limited to the minimum amount of information needed to accomplish the purpose of the request or disclosure.

Melissa D. Wright, MA, LPC of Wright Resolutions, LLC use or disclose individual's Protected Health Information (PHI), as defined in the Health Insurance Portability and Accountability Act of 1996, for the purpose of conducting, planning and directing your treatment, making or obtaining payment for care, or otherwise allowed by HIPAA. We may use or disclose your PHI for purposes permitted or required by federal, state, or local law, for example, if it is court ordered, or if it is determined in the course of care that you are a danger to yourself or others.

Also, it is mandatory that we report child abuse. Finally, you may explicitly give permission to release your information as determined to be helpful in the therapeutic process.

Melissa D. Wright, MA, LPC of Wright Resolutions, LLC not share your information with anyone for their own marketing purposes. For this reason Melissa D. Wright, MA, LPC of Wright Resolutions, LLC is not required to obtain an "opt-in election," or an "opt-out election."

I have read the HIPAA Privacy Policy.

Client/Guardian Signature _____

Date_____

Client History and Demographics

Name:_____
Date:_____
DOB / Age: _____ Gender: Male/ Female

Briefly, what is the reason for seeking counseling services at this time?

_____
_____
_____

Highest Level of Education Completed / Year Graduated:

_____
Occupation:

_____
Current Employer / School:

_____
Marital Status: Single Married / Civil Union Widowed Separated Divorced
Partner's Name, If applicable:

_____
Children: Yes No If yes, ages:

_____

Medical History

Do you have a chronic / serious health conditions: Yes No
If yes, please explain:

_____
_____
_____
Any allergies (including foods and medications): Yes No
If yes, please explain:

_____
_____
_____
Current Medications:

Medication	Condition	Dose	Frequency	Compliant:	Effective:
				Yes No	Yes No
				Yes No	Yes No

				Yes No	Yes No
				Yes No	Yes No
				Yes No	Yes No

Are you currently working with a therapist: Yes No
If yes, please provide name, phone number, and address:

_____

_____

Are you currently working with a psychiatrist: Yes No
If yes, please provide name, phone number, and address:

_____

_____

Do you have a primary care physician (PCP) or family doctor: Yes No

Client History and Demographics
Client Name:_

_____

If yes, please provide name, phone number, and address:

_____

_____

Family/ Childhood History

Growing up, with whom did you reside:

_____

Do you have any siblings: Yes No
If yes, please provide gender and ages:

_____

_____

Have you ever experienced abuse or neglect: Yes No
If yes, please explain: Physical Emotional Sexual Neglect

_____

_____

_____

Social History

What are your hobbies / interests:

_____

_____

_____

With whom do you spend your free time:

_____

_____

_____

Who do you consider your (emotional) support system:

_____

_____

_____

Do you engage in any drug and/or alcohol use (note substance, age started, and frequency):

_____

_____

_____

_____

For clients under the age of 18

With whom do you reside:

_____

Mother's name and phone number:

_____

Father's name and phone number:

_____

Are your parents: Married Separated Divorced Never Married Widowed

Page 3:

Client History and Demographics

Client Name:_

_____

Stepmother's name and Phone Number:

_____

Stepfather's name and phone number:

_____

Do you siblings reside with you? If no, specify where they reside:_____

_____

_____

Any additional information that you would like to share:

_____

Name: _____ Date: _____

Please rate the symptoms you have been experiencing in the last two weeks on a scale of 0 to 3.

0-N/A 1 Mild- once every two weeks 2 Moderate-once a week 3 Severe-four or more times per week

Feeling depressed	
Feeling anxious	
Feeling overwhelmed	
Feeling hopeless	
Sleep Less Than 6 hours most nights	
Sleep More Than 10 hours most nights	
Loss of appetite (in past month I have lost _____Lbs.)	
Increase in appetite (in the past month I gained ____Lbs.)	
Panic attacks	
Thoughts of suicide	
Thoughts of homicide	
Thoughts of hurting yourself	
I have hurt myself in the last week by: ___ Cutting; ___ Not Eating; ___ Overeating; ___ Purging ___ Abusing Substances; ___ Other	
Agitation, hyper	
Having irrational thoughts or fears	
Engaging in compulsive behavior	
Feeling confused	
Feeling restless or on edge	
Having mood swings	
Feeling lonely	
Having problems in relationships	
Feeling irritable	
Feelings of unreality	
Feeling of being detached from oneself	
Tearful	
Excessive worrying or obsessions	
Nightmares	
Feelings of apathy or indifference	
Having problems sexually	
Isolating and avoiding interaction with others	

Having negative thoughts about your future	
Having negative thoughts about yourself	
Having negative thoughts about your situation	
Having racing thoughts	
Having trouble concentrating	
Having trouble remembering things	
Feeling unable to go to work, school, etc.	
Feeling unable to keep up with family life and social life	
Feeling unable to keep up with household chores	