ART THERAPY & Creative Counseling
80-1 Plains Rd. Essex, CT 06426

CLIENT REGISTRATION AND POLICY FORM

CLIENT INFORMATION			
Date		Age	
Name *Last, First, Middle*			
Street Address			
Town		Zip	
Birth Date		Gender	
Email Address		Phone	
Occupation and Employer			
Emergency Contact Person		Phone and Relationship	

PARENT or LEGAL GUARDIAN INFORMATION *Please complete if client is under age 18.*			
Name		Relationship	Parent Guardian
Custodial Arrangement	Parents Married Parents Divorced Other:	Primary Custodian (if applicable)	Mother Father
Email Address		Phone Number	
Occupation and Employer			

INSURANCE INFORMATION			
Person Responsible for Bill		Date of Birth	
Payer Relationship to Client	Self Parent/Guardian Spouse Other:	Is Client insured?	Yes No
Payer Address (if different than client)			

INSURANCE INFORMATION - CONTINUED

Town		Zip	
Name of Primary Insurance Provider		Name of Primary Policy Holder	
Identification Number		Co-Pay	$
Name of Secondary Insurance Provider (if applicable)		Name of Secondary Policy Holder	
Identification Number		Co-Pay	$

POLICIES

GENERAL	
Mandated Reporting	All clinicians are Mandated Reporters and are legally required to report any suspicion of abuse or neglect to the Department of Children and Families.
Availability Emergency	In the event of a psychiatric emergency or suicide crisis outside of regular business hours, call **211, 911** or **988** as needed or go to your local emergency room. **Clinicians are not available after business hours or weekends.**
Health	Clients should not attend a session if they are ill with a communicable disease. (e.g., vomiting, fever, coughing, etc.)
Parents	Parents/Guardians are to remain in the waiting area while their child or children are in session.
Payment	The insurance co-pay, co-insurance and self-pay amounts are due at the time of the service.
How to Cancel	Cancelling a session should be done using the voice application of your phone. Cancellations without 24 hours of notice are subject to a fee of **$85**.
Recording of Sessions	**The recording of sessions via video or voice technology is strictly prohibited as it breaches confidentiality and can compromise the clinician/client relationship.**
Texting	Please be advised that texting is not a secure form of communication. Please use your clinician's HIPPA-compliant email for sensitive messages.
Frequency of Sessions	Clients must be seen at least once every **6 weeks** to remain active on their clinician's caseload. Clients who are not able to return during this timeframe for maintenance sessions will be discharged.
FINANCIAL	
Acceptable Methods of Payment	In addition to submitting for insurance reimbursement, ATCC accepts cash, personal checks (made out to "ATCC"), and credit cards for payment. Your clinician may also accept "Square," a secure form of electronic payment.
Client Knowledge of Benefits	Insurance holders are responsible for knowing their outpatient mental health benefits and keeping track of their deductibles.
Rates	The list below identifies the most common current service rates used by ATCC.

Service	Time	Charge	Billing Code

Initial Consultation (Individual)	53 minutes	$200	90791
Individual Therapy	53 minutes	$ 200	90837
Therapy	45 minutes	$ 175	90834
Therapy	30 minutes	$ 150	90832
Family Therapy	53 minutes	$ 200	90847
Group Therapy	50 minutes	$ 50	90853
Fees Not Covered by Insurance			
Missed, Cancelled or Late session without 24 hours of notice	$85/ 15 mins late *If you are not feeling well, please inquire about a virtual session prior to cancelling.*		
Returned Check Fee	$35 *Future payments must be credit card or cash*	Clinical Letters Court Letters	$65 $350 plus
Return Phone Calls	$10/minute pro-rated	Court Fees: Preparatory Work	$300/hour to prepare testimony, documents, travel etc.
Parent Pupil Teacher (PPT) Meeting Advocate	$200/meeting	Court Fees: Testimony	$1,500/day *Advance Deposit Required*
Transaction Fees for Refunds on Square	3.5 % fee deducted for full or partial refunds on services.Insurance holders are responsible for knowing their mental health benefits.		

IMPORTANT NOTICE

In the event a client refused to pay the agreed upon fees, ATCC may resort to legal means (e.g, an attorney or collection agency) to secure payment. If such legal action is necessary, the client will be responsible for all costs associated with collecting the fees.

If the insurance company provided denies a claim filed on behalf of a client, the client is responsible to pay ATCC the difference between the standard rate and the amount previously paid, unless otherwise approved by the owner of Art Therapy & Creative Counseling.

I agree to: (1) Give permission to release any information the insurance company may require in order to process payment, (2) Appoint Ace Medical Billing as my authorized representative in obtaining payment and billing directly for services provided, (3) assign all of my rights to claims and payment by my insurance, and (4) agree to assist with the claims process as required by ATCC or my insurance provider.

I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

I have read and understand the policies in this document and agree to its terms and conditions.

_____ _____

Signature of Client (or Parent/Guardian if client is under age 18) Date

CREDIT CARD ON FILE

Please provide your credit card information. You may list a regular credit card or HSA or FSA card. This information will be stored on ATCC's secure electronic platform for your convenience in charging co-pays, co-insurance, deductibles, cancellation fees, missed appointment fees, returned check fees, or past-due account balances or transaction fees. Clients who do not use insurance may also use this

For a CREDIT CARD			
Name on Card		Town Zip Code	
Type of Card	Visa Master Card Discover American Express		
Card Number (16 digits)	:___ ___ ___ ___- ___ ___ ___ ___ -___ ___ ___ ___-___ ___ ___ ___		
Expiration		Security Code	
For a FSA or HSA CARD			
Name on Card		Town Zip Code	
Type of Card	Visa Master Card Discover American Express		
Card Number (16 digits)	:___ ___ ___ ___- ___ ___ ___ ___ -___ ___ ___ ___-___ ___ ___ ___		
Expiration		Security Code	

AUTHORIZATION

I agree to have this card charged by ATCC as appropriate for services or fees incurred.

_____ _____

Signature Date

Email Address to send receipt	

Thank you for choosing Art Therapy & Creative Counseling.
We look forward to working with you.