



CLIENT REGISTRATION - 2023

CLIENT NAME _____

LAST

FIRST

MIDDLE

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

SS# _____ SEX _____ DATE OF BIRTH _____ AGE _____

IF STUDENT: NAME OF SCHOOL _____ GRADE _____

INSURANCE POLICY HOLDER NAME _____ DOB _____

PARENT / GUARDIAN (If Patient Is A Minor) _____

CONTACT NUMBER FOR PARENT/GUARDIAN _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

PHONE NUMBER _____

Best Phone Number to Receive Text Reminders _____

Name of Contact (If client is a minor) _____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all my insurance submissions
2. I authorize the release of information to my insurance company
3. I understand that I am responsible for the full amount of my bill for services provided
4. I authorize direct payment to my service provider
5. I hereby permit a copy of this to be used in place of an original

It is your responsibility to pay any deductible amount, copay, co-insurance amount or any other balance not paid by your insurance at the date and time services are provided. No checks are accepted – Credit card or Cash only. If your account goes into collection, there will be a 20% fee added to your balance. _____ Initials



Veronica Lichtenstein LMHC

LET'S TALK ABOUT IT

CONSENT TO TREATMENT

I hereby authorize Veronica Lichtenstein LMHC, LLC to administer mental health/psychiatric treatment. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that Veronica Lichtenstein LMHC, LLC may be obligated to release information to my insurance company from my medical records as determined and required by my company's guidelines and hereby authorize the release of such information. I authorize the release of pertinent information for collection purposes should it be necessary. I hereby consent to receive consumer survey material following completion of treatment for the purposes of evaluating my satisfaction with the effectiveness of services rendered by Veronica Lichtenstein LMHC, LLC.

_____ Initials

For minors: I represent and warrant that all information submitted is true and correct and that I have complete and proper authority to involve the above referenced minor client for treatment at Veronica Lichtenstein LMHC, LLC. I understand that Veronica Lichtenstein LMHC, LLC is relying upon my representation to accept the minor child as a client and I shall hold harmless and indemnify Veronica Lichtenstein LMHC, LLC as the result of any representations which are not true and correct.

_____ Initials

EMDR Therapy: If I am offered EMDR therapy and choose to participate, I hereby consent to participating and acknowledge my consent is free from pressure. I agree to hold harmless Veronica Lichtenstein, LMHC, LLC from any unpleasant, or unexpected affects, which may arise from my experience. I understand that I may stop treatment at any time before or during my EMDR session, and that more than one 50-minute session is encouraged for treatment.

_____ Initials

POLICIES AND PROCEDURES

Veronica Lichtenstein LMHC, LLC maintains the highest of professional and ethical standards. To serve our clients to the best of our ability, we request that you review the following policies and procedures prior to your initial session. Should you have any questions or concerns prior to signing acknowledgment of these terms, please discuss these issues with your therapist or the office manager at [**561-903-TALK \(8255\)**](tel:561-903-TALK(8255)).

Emergency Services: Veronica Lichtenstein LMHC, LLC **does not** provide 24-hour emergency coverage. Should you have a potentially suicidal/homicidal situation, please call **911 IMMEDIATELY** or go directly to the emergency room of the nearest hospital based on the severity of the situation. You may also contact the National Suicide Prevention Lifeline 24 hours a day / 7 days a week if you are experiencing a clinical emergency at [**800-273-8255**](tel:800-273-8255) or dial **988**.

_____ Initials

Confidentiality of Relationship: All information given by you or your family is treated as confidential and may be released only upon your written consent or as required by law. The legal limitations to confidentiality include: Suspected or reported child abuse/neglect, suspected or reported situations in which your therapist believes to be potentially life threatening to yourself or others, or should a court order require your therapist to provide information to the courts.

_____ Initials



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LET'S TALK ABOUT IT

Letter Writing and Forms: If you would like Veronica to write a letter on your behalf, please reach out to the office for details. In general, we require:

1. You must be a current client (must have been seen within the past three months)
2. Your request with specifications must be in writing and can be sent to talk@veronicalistens.com
3. Letters will be produced within one week.
4. Fee is \$150 per letter.

Please note: Veronica does not participate in any employment/disability determinations.

_____ Initials

Phone Contacts: Telephone calls, consultations and correspondence will be billed at therapy rate of \$100 in 15-minute increments. At times, a client will request that Veronica reach out to other clinicians etc for collaboration. Veronica will be happy to do this and please take note of her fees. These are not covered by insurance.

_____ Initials

Court Testimony: We do not believe that it is advantageous to expect your therapist to testify in court. Veronica Lichtenstein, LMHC LLC does not make court appearances. You can read more about court documents and subpoenas in her [Policy and Informed Consent for Couples and Families](#) on her website.

_____ Initials

Sessions: Please respect that your sessions are scheduled for 45-50 minutes. Most insurance companies cover one 50 minute session per day. We ask that you arrive for your session on time. Your session will be limited to the original scheduled time. Should your therapist be responsible for the session starting late, you will receive your entitled session time. Sessions are currently \$200 for self-pay and last 45-50 minutes. Longer sessions for more intensive treatment (Ex: EMDR, Family) can be arranged. In this instance, please contact the office. Most insurance companies pay for a 50-minute session, unless otherwise noted.

_____ Initials

Telehealth Sessions: Now that Covid-19 Quarantine has lifted, phone sessions are limited and not encouraged, as Veronica believes the best work is done in person. If you decide to use a phone or video chat modality, please check with your insurance company to make sure it is still covered. I hereby authorize Veronica Lichtenstein, LMHC, LLC to administer mental health/psychiatric treatment via Telehealth. Telehealth treatment shall be defined as Phone or secure Online Video using a HIPAA compliant platform. All stipulations made in the above paragraphs will hold true for Telehealth the same as in person sessions. Veronica's video session website is doxy.me/vlicht

_____ Initials

Co-Pays/Coinsurance and Deductibles: Our office is unique in that there is no support staff on site and all monies are collected by a credit card that is kept on file. A credit card is required to book any appointment. Cash is also accepted although not preferred, however you must have exact change. Co-pays, deductibles, late fees are due prior to appointment to avoid rescheduling. The less administrative work done in the office, the more time Veronica has for therapy with you. We encourage you to utilize our off-site support services. Our office is quick to return emails (talk@veronicalistens.com) or calls (561) 903-TALK (8255) and this guarantees the most efficient service for you.

_____ Initials



Veronica Lichtenstein LMHC

LET'S TALK ABOUT IT

Canceled / Missed Appointments: Appointments must be canceled by midnight before your scheduled appointment. For weekend Appointments ONLY, **you must cancel by midnight on Friday night.** You may call **561-903-8255** or email **talk@veronicalistens.com** or **v@veronicalistens.com** to notify us of your cancellation. We reserve the right to charge a fee for missed or late canceled appointments. Your insurance company will not pay for missed appointments; **therefore you will be responsible for this fee which is currently \$150.**

_____ Initials

Insurance Premiums: From time to time we receive notification that a policy has lapsed or is in a "grace period" due to non-payment of the premium. Please be advised that when we receive such a notification we will suspend your appointments until the insurance company confirms the policy is back in effect. Or you will have the option of paying the full rate of the session at \$200 per 50 minutes.

_____ Initials

TEXT AND EMAIL CORRESPONDENCE

I acknowledge the use of secured and unsecured text and email correspondence to and from the office of Veronica Lichtenstein LMHC, LLC and release any liability to Veronica Lichtenstein LMHC, LLC should any confidential information be transmitted. I have also read Veronica Lichtenstein, LMHC LLC [Social Media Policy](#).

_____ Initials

INSURANCE WAIVER

All services that we provide to you in our office will be billed to your insurance company. Any services not paid by your insurance company will be your responsibility. Due to the magnitude of changes within the insurance companies, we are unable to pre-verify benefits for all insurances, as many companies subcontract their outpatient mental health benefits. Clients need to be aware of their own insurance benefits and what will be covered by their plans. It is your responsibility to obtain prior authorization if it is required by your insurance company. In addition, it is the responsibility of each client to be sure that your provider is participating with the insurance plan.

_____ Initials

HIPAA SIGNATURE

I acknowledge receipt of [HIPAA Notice of Privacy Practices](#) and the Office Policies and General information agreement for psychotherapy services. This signature page will be placed in your medical chart. Should you have any questions please address them with our office staff or your individual therapist.

_____ Initials

I hereby acknowledge that by signing below I accept and understand the above Office Billing and Insurance Policy, Consent for Treatment, Policies and Procedures, Insurance Waiver, and HIPAA Signature.

Signature of Client

Date

Name of Client (Print)

Witness / Therapist Signature

Date