THE CENTER FOR Relational HEALING

GROUP REGISTRATION

GENERAL INFORMATION

Today's Date:_____/_____/_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone/cell: _____ Okay to text? ☐ Yes ☐ No

Email: _____

Emergency contact: _____ Contact's phone: _____

Emergency contact's relationship to you: _____

Whom may I thank for referring you? _____

FAMILY & RELATIONSHIP INFORMATION

Present Relationship Status (check all that apply):

- ☐ Married (yrs:___ mos:___)
- ☐ Partnered (yrs:___mos:___)
- ☐ In a new relationship (6 mos or less)
- ☐ Other: _____

If married, partnered or in a primary relationship, do you live with your significant other? ☐ Yes ☐ No

Others living in your household:

Name	Relationship	Age

MEDICAL INFORMATION

Primary Therapist: _____ Phone: _____
Psychiatrist: _____ Phone: _____
Other Specialist: _____ Phone: _____
Are you in recovery for addiction or compulsion? ❑ Yes ❑ No What program(s)? _____
Are you currently sober? ❑ Yes ❑ No How long? _____
List any medications you are currently taking (including non-prescription or herbal remedies): _____
_____
Describe any current physical and/or psychiatric concerns that you have: _____
_____

CONSENT FOR TREATMENT AND OFFICE POLICY

This consent is to certify that you agree to participate in weekly group therapy group and that you give permission to your CRH therapist to provide psycho-education and psychotherapy services.

CONFIDENTIALITY

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you to convey information to a third party. There are certain exceptions to this:

- When there is a reasonable suspicion of child abuse, dependent-adult or elder abuse.
- When a client threatens violence to an identifiable victim.
- When a client presents a danger of violence to others.
- When a client is likely to harm him/herself unless protective measures are taken.
- When a client states that he or she has downloaded, streamed or accessed through any electronic or digital media depictions in which a child is engaged in an act of obscene sexual conduct.

Disclosure may also be required in certain legal proceedings. *If you have concerns about the content of sessions and any legal proceedings in which you are involved or expect to be involved (e.g., divorce, child custody cases), please let your therapist know.*

Before such disclosure is made, every reasonable effort will be made to appropriately resolve these issues or to notify clients.

ALL clients shall maintain the confidentiality of other participants and are not permitted to disclose any personal and/or identifying information about any other participant. This boundary is critical for client safety.

CONTACTING THERAPISTS

Clients may email, text or leave a voicemail for their group therapist at any time. Please be aware that therapists may not be able to immediately retrieve messages but every effort will be made to return calls within 24 hours. **If you have a life-threatening emergency, dial 911 or go to the nearest emergency room.**

FEES, BILLING & PAYMENTS

In order to prevent any misunderstandings about payment for services, please be advised of the following:

(1) All services provided are billed directly to the client unless other arrangements have been made;
(2) Clients are personally responsible for payment via credit card, cash, check or money order;

(3) Statements can be provided for you to submit for insurance reimbursement;
(4) You are responsible for submitting all claims to your insurance provider;
(5) If payment is not received when services are rendered, payment may be applied to the credit/debit card on file if no other payment arrangements have been made.
(6) If your credit/debit card is invalid and you have made no other payment arrangements, your past due balance may be sent to an agency for collection.

Payment Guarantee: clients are responsible for all incurred charges, even if you direct us to bill another person or third party. If you direct charges to be billed to another person or third party, you represent that you are authorized to give such direction. If you have directed charges to be billed to another person or third party who fails to make payment, you will be responsible for payment.

CREDIT CARD AUTHORIZATION

Credit Card Authorization: I authorize the maintenance of valid credit card information to guarantee my chosen payment option.

Cardholder Name:_____

Billing Address:_____

City: _____ Zip: _____

Circle Card Type: Visa MC Discover AmEx

Credit Card #_____ Expiration date: ____/____/_____

3 digit CVV code: _____

Cardholder/Client Signature: _____ Date:____/____/_____

The fee for the group is $75.00. Group will be paid for on a monthly basis. Clients are responsible for submitting all claims to their insurance provider.

I have read, understand and agree to the authorization stated above

Signature:_____ Date:_____

Printed Name: _____