RANDY FONTENOT, M.A., LPC-S, LMFT
Counseling & Consulting Services, LLC
5329 Dijon Drive, Suite 105, Baton Rouge, LA 70808
Phone: 225-276-8428 Email: randy@counselingbr.com

CLIENT REGISTRATION FORM

(Please Print)

Today's Date:	**PCP:**

CLIENT INFORMATION

Last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Gender:

Street address:	City & State:	Zip code:

Home/Cell Phone no.:	E-mail address:	Social Security No.

Occupation:	Employer:	Employer phone no.:

Referred by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:

Is this person a client here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this client covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ Cigna	☐ Aetna	☐ BlueCross Blue Shield	☐ United Health Care	☐ Humana

☐ MHN	☐ EAP	☐ Value Options	☐ *Other:*	☐

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Member no.:	Co-payment: $

Client's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Member no.:

Client's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company for billing purposes.
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.
6. I understand that it is my responsibility to pay any insurance deductibles, co-pay, co-insurance amount or any other balance not paid by my insurance on the day and time services are provided.
7. I understand that a notice of unpaid balances will be mailed to the address on this form.
8. There will be a $35.00 service charge for all returned checks.
9. In the event that your account goes to collections, there will be a 25% collection fee added to your balance.
10. **There is a 24-hour cancellation policy, which requires that you cancel your appointment 24-hours in advance to avoid being charged a $75.00 missed appointment fee.**

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize Randy Fontenot or insurance company to release any information required to process my claims.

Client/Guardian signature *Date*

Notice of Privacy Practices (Brief Version)

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is and can be reached by phone at or by e-mail at

Name: _____ Date: _____

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DECLARATION OF PRACTICES AND PROCEDURES

QUALIFICATIONS:

I am licensed as a Professional Counselor (#2810) and Marriage and Family Therapist (#1178) by the Louisiana Board of Examiners for Licensed Professional Counselors, which is located at 8631 Summa Avenue, Baton Rouge, LA 70809, (225) 765-2515. I earned a Master of Arts degree in Community Counseling from Louisiana State University in 2001. The Council on Accreditation of Counseling and Related Educational Programs accredits the masters program that I completed.

COUNSELING RELATIONSHIP:

Counseling is a process in which you, the client, and I, the Professional Counselor/Marriage and Family Therapist, having come to understand and trust one another, work as a team to explore and define problem situations, and life patterns; develop future goals for an improved life, and work in a systematic fashion towards realizing those goals. Upon entering this counseling relationship, you will make an important step in resolving the issues you are currently facing. Although our sessions may be very intimate, emotionally and psychologically, it is important for you to realize that we have a professional relationship rather than a personal one.

AREAS OF FOCUS:

Although my experience includes addressing a generality of client issues, my expertise is in treating depression, anxiety, addictions, behavior modification, relationship issues, and personal development.

FEES:

I accept most major insurance plans. All co-payments must be paid in full at the end of each session. Because copayments are an insurance requirement, we cannot bill you for these. Methods of payment are cash, credit card, or checks. The fee for my counseling service will be discussed upon initial contact.

THE FINAL OBLIGATION FOR PAYMENT RESTS WITH THE CLIENT, NOT THE INSURANCE OR MANAGE CARE COMPANY.

APPOINTMENTS:

Appointments are typically set at the close of each session. Appointments may be scheduled, rescheduled, or cancelled by calling 225-276-8428. Same day appointments are not available. **There is a charge for failed appointments/late cancelation if less than 24-hour notice is given. You will be charged $75.00 for the service, which would have been rendered**. Appointment reminders are offered as a courtesy. It is the client's responsibility to remember all scheduled appointments.

TELEPHONE AND EMAIL CONSULTATIONS:

Are available on a fee basis at $150 per hour during business hours only. It is expect that you respect my privacy in this matter.

LITIGATION LIMITATION:

Given that certain types of litigation may lead to the court-ordered release of information without your consent, it is expressly agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits etc.) neither you or any attorney, or anyone else acting on your behalf, will ask me to testify in a deposition or in court or any other proceeding, nor will a disclosure of the medical record and/or psychotherapy notes be requested.

Over for page 2

SERVICES OFFERED AND CLIENTS SERVED:
The theoretical basis for my counseling services is based on the cognitive-behavioral model. That is, patterns of thoughts and actions are explored in order to better understand the client's issues. I frequently integrate other theoretical approaches. My counseling services are offered on an individual basis, couple, family, and group.

CODE OF CONDUCT:
I am required by the state law to adhere to the Code of Conduct for Licensed Professional Counselors and the Code of Ethics for Licensed Marriage and Family Therapist, which have been adopted by the Louisiana Licensed Professional Counselors Board of Examiners. A copy of these codes will be made available to you upon your request.

PRIVILEGED COMMUNICATIONS:
I am required to abide by the professional practice standards for Licensed Professional Counselors and Louisiana Law. Therefore, material revealed in counseling will remain strictly confidential except for material under the following circumstances in accordance with state law: (1) The client signs a written release of information indicating informed consent of such release, (2) The client expresses intent to harm him/herself or someone else, (3) There is reasonable suspicion of abuse/neglect against a minor child, elderly person (60 or older), or a dependent adult, or (4) a court order is received directing the disclosure of information.

It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if possible, except during an emergency, before mandated disclosure. I will endeavor to let clients know of all mandated disclosures as conceivable.

In the event of marriage or family counseling, material obtained from an adult client individually may be shared with the client's spouse/partner or other family member only with the client's permission. Any material obtained from a minor client may be shared with the client's parent or guardian.

AFTER- HOURS/EMERGENCY SITUATIONS:
After normal office hours or in the event that your call is not answered, you may leave a voicemail message and I will return your call as soon as possible.

In an emergency situation when an immediate response is necessary, you may call the Crisis Intervention Center or the PHONE at (225) 924-3900, which offers professional services 24-hours a day. You may also seek help through hospital emergency facilities or by dialing 911.

CLIENT RESPONSIBILITIES:
As a client, you will be required to be honest and a willing participant in growth and development during treatment. You, the client, are a full partner in counseling. If as we work together you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make necessary adjustments. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate our services to you. If it develops that another mental health provider will better serve you, I will assist you with the referral process.

Clients must make their own decisions regarding such things as deciding to marry, separate, divorce, reconcile, and how to set up custody and visitation. I will help you think through the possibilities and consequence of decisions, but my code of ethics does not allow me to advise you to make a specific decision.

PHYSICAL HEALTH:
Physical health can be an important factor in the emotional well being of an individual. If you have not had a physical examination in the last year; it is recommended that you do so. As a routine part of the initial session, you will be asked the name of you physician and to list any medications that you are now taking.

POTENTIAL COUNSELING RISK:
During the counseling process the client may realize that he or she has additional issues, which may not have surfaced prior to the onset of the counseling relationship. If changes in your behavior occur in response to counseling, strain may be placed on your relationship with others who must adjust to your new behavior.

I have read and understand the above Declaration of Practices and Procedures/Statement of Practice of Randy Fontenot, M.A., LPC-S, LMFT and my signature below indicates my full informed consent to services provided by Randy Fontenot, M.A., LPC-S, LMFT

Client Signature _____ Date_____

Client Signature _____ Date _____
(If couple)

If client is a minor, parental authorization is required: I, _____, give my permission for Randy Fontenot to conduct counseling with my _____, _____.
(Relationship) (Name of Minor)

Randy Fontenot, M.A., LPC-S, LMFT _____ Date_____

Randy Fontenot, M.A., LPC-S, LMFT
Counseling & Consulting Services, LLC

FINANCIAL POLICY

This is an agreement between Randy Fontenot, as the therapist/creditor, and the Client/Debtor named on this form.
In this agreement the words "you", "your" and "yours" mean the Client/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited, the words "we", "us", and "our" refer to the counseling practice of Randy Fontenot.
By executing this agreement, you are agreeing to pay for all services that are received.

PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE.
You may pay by cash, check or credit card on the day that services are rendered.

Required payments: Any co-payments, deductibles or coinsurance required by an insurance company must be paid at the time of service. Because copays are an insurance requirement, we cannot bill you for these.

Returned checks: There is a fee (currently $25) for any checks returned by the bank. A certified mail fee may also apply if a check is not paid once re-deposited to the bank. Two or more returned checks will result in the account being placed on a cash only status. Checks reported to the Justice of the Peace and/or Police Department may include possible discharge from the practice.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt, including involving collection agencies and possible discharge from the practice.

Wavier of confidentiality: You understand if this account is submitted to an attorney, collection agency or reported to a credit reporting agency, the fact that you received treatment at this practice may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Cancelation Notice: ***There is a charge for failed appointments/late cancelation if less than 24 hour notice is given. You will be billed $75.00 for the service which would have been rendered. Appointment reminders are offered as a courtesy. My initials indicate that I have read and understand the above statement _____.***

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in force and effect.

Signature Date

Witness Date