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Zsuzsi Gero, M.A., LCMHC
60 Main Street, Suite 300, Nashua, NH 03060
ZGero@me.com ∗ (603) 809-6009

CLIENT REGISTRATION FORM

CLIENT INFORMATION

First Name:	Last Name:	Date of Birth:
Employer: School:	☐ Full time ☐ Part time ☐ Other: ☐ Full time ☐ Part time ☐ Other:	
Partner status ☐ Single ☐ Married ☐ Other		
Gender: ☐ Male ☐ Female ☐ Other:		
Address: Street: City/Town State Zip		
Home phone:	Email address:	
Work Phone:	Fax:	
Mobil Phone:	At which phone number do you prefer to be contacted?	

EMERGENCY CONTACT

Name of Emergency Contact Person:	Phone:
Client's Relationship to Emergency Contact Person: ☐ Spouse ☐ Child ☐ Other:	
Name of Primary Care Physician:	Phone:

If client is under 18 or has legal guardian:

Name of parent/guardian:			
Street Address: City/Town State Zip			
Home phone:	Work Phone:	Mobil Phone:	Email:

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
Health Insurance Name:			
Type of plan: ☐ HMO ☐PPO ☐Other:			
ID #:			
Group #:			
Who's insurance is this? Subscriber's Full Name:			
Subscriber's Address: Street: City/Town State Zip			
Subscriber's Employer:	Subscriber's Date of Birth:		
Subscriber's Gender: ☐ Male ☐ Female ☐ Other Client's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Referral/Auth # (if applicable) Eff date: # of visits:			
Copay amount:	Deductible amount:		

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Informed Consent and Service Agreement

Important information about using your Health Insurance

You (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator.

"Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. I will make every effort to release only the minimum information about you that is necessary for the purpose requested. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. You always have the right to pay directly for my services, instead of using an insurance or similar benefit, to avoid the problems described above.

Release of Information: I authorize the release of any medical or other information necessary to process claims for my health insurance carrier. My health insurance carrier has permission to speak with my therapist about information pertinent to my care. My therapist may allow my insurance carrier to review my medical records and may send a note to my insurance carrier summarizing my treatment. **Please initial**:_____

Assignment of Insurance Benefits: I authorize direct payment of benefits to Zsuzsanna Gero, LCMHC for services rendered. I understand that I am financially responsible for any balance not covered by my insurance, including co-pay, deductible amount, missed session fee, cancellation fee, rejected or unpaid claims, legal services fees etc. **Please initial here: _____**

Cancellation policy
I understand that my insurance benefits do not include missed and cancelled sessions. I acknowledge the necessity of a 48-hour notice for cancellation of an appointment. If I do not notify for cancellation prior to this 48 hours, I will be responsible for half of my session fee. If I do not notify for cancellation 24 hours prior to my session I will be responsible for the full session fee. **Please Initial: _____**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS

Signature: _____ Date: _____

Printed name: _____

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Payment/ Fees

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

My fees are as follows*:

Type of Appointment:	Fees:
Initial Psychodiagnostic Evaluation (60min)	$167
Individual Psychotherapy Appointments (50min)	$157
Coaching calls (15 min)	$20

Cancellation/Missed appointments *

Cancellation with less than 48 hours notice	$35
Missed session / Cancellation with less then 24 hours notice	full fee

Legal/Medical Record Fees:

Type of Service	Fees:
Confirmation letters regarding attendance and treatment:	$0
Treatment Summary (1-2pages):	$30
Preparing all treatment notes and records for release:	$50
Appearence at Court (per hour w commute included)	$157
Returned Check fee	$20

* My fee may increase with 30 days written notice.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to view your records unless I believe that seeing them would be emotionally damaging, in which case I can provide a summary of the records instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them or the summary I provide with me or with the mental health professional of your choice. In the event of my incapacitation or death, my trusted Professional Executor may take control of records and contact you.

Minors

If you are under 18 years of age, please be aware that the law provides your parents/guardians with the right to examine your treatment records. Minors over the age of 16 have additional rights. It is my policy to request that your parents/guardians agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel that there is a high risk that you will seriously harm yourself or someone else, if you are being abused, or if you are abusing someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment once it is complete. Before giving them any information, I will discuss this matter with you, if possible, and do my best to handle any objections you may have about what I am prepared to discuss. If under 18, GUARDIANS' INITIALS: _____

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HIPAA Privacy Practices

I have a legal duty to safeguard your protected health information (PHI)
I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI.

How I may use and disclose your PHI
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent as indicated by your signature on the document regarding the receipt of this notice. To help clarify these terms, here are some definitions: • "PHI" refers to information in your health record that could identify you. • "Treatment, Payment and Health Care Operations"
– Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
– Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. * Signing this document gives me permission to release to your insurance company the information needed to obtain payment for my services.
– Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
• "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. •"Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties. I may disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

Certain uses and disclosures require you to have the opportunity to object, such as disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

II. Uses and Disclosures with Neither Consent nor Authorization
I may use or disclose PHI without your consent or authorization in the following circumstances:
• **Child Abuse:** If I, in my professional capacity, have reasonable cause to believe that a child (under 18) is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, I am mandated to report such condition to the New Hampshire Department of Health & Human Services.
• **Incapacitated Adult and Elderly Abuse:** If I have reasonable cause to believe that an elderly person or an incapacitated adult whose physical, mental, or emotional ability is such that he is unable to manage personal home, or financial affairs in his own best interest, or he is unable to act or unable to delegate responsibility to a responsible caretaker or caregiver is suffering from or has died as a result of abuse, I must make a report to New Hampshire Bureau of Elderly and Adult Services.
• **Health Oversight:** State licensing boards have the power, when necessary, to subpoena relevant records in the course of investigating a complaint filed with them should I be the focus of an inquiry.
• **Judicial or Administrative Proceedings**: The Office of the Attorney General and the Division of Behavioral Health have access to all records and information pertaining to you when you are the subject of

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an involuntary commitment hearing, a guardianship proceeding, or when you have instituted legal action against the state in regard to care and treatment provided by your mental health service provider. If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

• **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you have a history of physical violence and I believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment, and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you. Only specific information necessary to the relief of the emergency may be released without the client's consent.

• **Worker's Compensation:** If you file a workers' compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the NH Labor Board.

• **Event of death:** Your records shall be retained for 7 years after discharge for adults and 22 years beyond the age of 18 for children. In the event of death, records may only be released upon the consent of the court-appointed Administrator of the Estate. The Office of the NH Medical Examiner may access medical records of a deceased individual

III. Uses and Disclosures Requiring Prior Written Authorization

In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family psychotherapy session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at (603) 809 - 6009 for further information.

If you believe that your privacy rights have been violated or you disagree with a decision I made about access to your PHI and wish to file a complaint with me, you may send your written complaint to me at my office address noted below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices. If you have any questions about this notice or any complaints about my privacy practices, please contact me at:
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Effective date of privacy practices
These privacy practices went into effect on November 17th, 2008.

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REMINDERS

APPOINTMENTS, FEES & CANCELLATION POLICY

- Counseling sessions are approximately 50 minutes in length. Longer sessions may be arranged.
- If you are late for you appointment, the session will still end on time.
- You will be charged $35 for cancellations less than 48 hours prior to appointment time, and full fee for cancellations less than 24 hours prior to appointment time or for which you do not show. I may make exceptions in the case of emergencies or sickness.
- There is a $25.00 fee for returned checks
- My office phone number is (603) 809-6009. I am often not immediately available by telephone. I usually return calls within 24 hours, with the exception of weekends and holidays. Please note that messages left on Friday afternoon will most often be returned the following business day.
- If you are unable to reach me and feel that you can't wait for me to return your call, contact your primary care physician or the nearest emergency room and ask for the behavioral/mental health clinician on call.
- Email/Text messaging: E-mail and Text messaging is not a secure form of communication, and I cannot guarantee that the information you disclose in an e-mail or text message will not be intercepted by a third party. Therefore, e-mail is not an appropriate means of communicating confidential or urgent information to me. Therapy sessions are never conducted via e-mail
- My fee may increase with 30 days written notice.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will notify you in person or by mail.

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Signature for Informed Consent and Privacy Practices

I _____(your name) have chosen to receive psychotherapy services from Zsuzsi Gero, LCMHC. My choice has been voluntary and I may terminate psychotherapy at any time.

I understand that upsetting material may be discussed during the course of my treatment and I might experience uncomfortable feelings in the course of psychotherapy. I understand that processing upsetting material and uncomfortable feelings might be necessary to help me achieve my goals.

My signature below indicates that I have read or have had satisfactorily explained to me and I understand Zsuzsi Gero's **"Informed Consent and Service Agreement"** as well as the **"HIPAA Privacy Practices"**. Any questions that I had about this statement as well including fees and payment policies have been answered and explained to my satisfaction. I understand and agree to the description of confidentiality and its' exceptions as stated above. I consent to counseling under the terms described above. A copy of these documents has been made available to me and I can also obtain them online at zgero.com.

CLIENT's NAME (please print) _____

CLIENT's SIGNATURE _____ DATE _____

(For clients under the age of 13, consent must be given and this form must be signed by either a parent or legal guardian.)

GUARDIAN'S NAME (please print) _____

GUARDIAN'S SIGNATURE _____ DATE _____

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INTAKE

NAME: _____ **DATE:** _____

Please complete the complete the following form as much as you can to provide preliminary information.

Referring clinician or person:

Identifying Info:

Living situation: ☐ Alone ☐ With Others; please specify: _____

School: _____ ☐ Full time student ☐ Part time student ☐ Other: _____

Occupation/ Employment: _____ ☐ Full time ☐ Part time ☐ Other: _____

Sex: ☐ Male ☐ Female ☐ Other: _____

Gender identity: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other: _____

Partner status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Other: _____

Number of marriages: _____ Length of previous marriages: _____

Age: _____ Ethnic/Cultural Heritage: _____ Religion/Spirituality: _____

Notes:

Chief/Presenting Complaint:
Why are you scheduling an appointment at this time? What do you want to discuss today?

Where and who do you reside with currently?

What do you do for work? Do you enjoy your job?

What medications are you currently taking? Please list with dosages and frequencies.

Please list any physical conditions including allergies that you have.

What drugs and/or alcohol do you currently use? Please list type and frequency of use.

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Associated Signs and Symptoms:
Please check all symptoms that apply to you

☐ Anxiety/Panic: _____ ☐ Depression: _____
☐ Decreased Energy: _____ ☐ Sleep Disturbance: _____
☐ Eating D/O: _____ ☐ Significant Weight change: _____
☐ Paranoia: _____ ☐ Impulsive/manic behavior: _____
☐ Obsessions/compulsions: _____ ☐ Sexually Inappropriate: _____
☐ Psychosis: _____ ☐ Anger/irritability: _____
☐ Relationship problems: _____ ☐ Work/School: _____
☐ Hyperactivity: _____ ☐ Inattention: _____
☐ Racing Thoughts: _____ ☐ Concentration/Focus: _____
☐ SI: active – passive – plan/ intent _____ ☐ Self-injurious behavior: _____
☐ HI: active – passive – plan/ intent _____ ☐ Substance Use: _____
☐ Other: _____: _____ ☐ Other: _____: _____

History of Presenting Problem:
Date/Onset – When did you first experience the above symptoms?

Frequency - How often do you experience the above symptoms?(circle the option that best describes your experience)

Several times a day --- Once a day --- Few times a week ----- Once a week ---- Few times a month ---- Once a month

Personal History:
Have you experienced, been the victim of or witnessed any of the following? If yes, please describe briefly.

☐ Physical abuse _____
☐ Sexual abuse _____
☐ Emotional abuse _____
☐ Financial abuse _____
☐ War or torture _____
☐ Legal troubles _____
☐ Suicidal thoughts _____
☐ Suicide attempts _____
☐ Homicide attempts/completions _____
☐ Eating disorders _____
☐ Self-injurious behavior (e.g., cutting) _____
☐ Hospitalization/inpatient treatment for mental health issues _____

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Psychosocial History:

Developmental:
Please describe your family growing up (with whom and where did you grow up; did your family move? If yes, when?)

How social were you growing up? How many and what kinds of friends did you have?

Relationship History:
Please list the number and length of significant romantic relationships/marriages you had.

Why and how relationships ended?

How would you describe your current relationship/marriage? How long have you been in this relationship?

Do you have any children? How many? How old? Do they live with you?

Traumatic Life events/Losses/Abuse Hx –
Did any of your family members, friends or people close to you die? How old were you?

What were the most dangerous situations you've ever experienced or witnessed?

Substance Use Hx:
What kinds of drugs have you tried or used? At what age and how long have you used?

Education/Vocational
How would you describe your academic performance history?

How many places have you worked at? Do you find your carrier fulfilling?

Medical/Nutritional/Spirituality/Self Care:
Have you had any major illness?

How would you describe your spirituality or religion?

What do you do to relax, to have fun or for self care? Do you have any hobbies?

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Prior Barriers to treatment
Have there been any barriers to seeking treatment sooner? Do you anticipate any barriers going forward?

Pertinent Family History:

Family Hx of Substance Abuse – Do you have family members with history of substance use?

Family Psychiatric Hx (Who, Meds, Suicide attempted/completed) – Do you have any family members with a history of significant illness, mental or emotional problems?

Filled out by clinician:

Mental Status:

Appearance:	Memory(immediate, recent, past)
Behavior:	Attention Span
Motor/Speech	Insight
Mood/Affect	Orientation:
Perception/Thinking Process	Judgment

Preliminary Diagnosis:

Treatment Plan:

_____ _____
Zsuzsanna Gero, LCMHC Date