Client Information and Registration Form

The information below is used strictly for processing and file keeping. All information is securely stored, encrypted, kept strictly confidential, and is maintained in compliance with HIPAA regulations. We assure you that the information given will be securely managed.

Client Information (PLEASE PRINT CLEARLY): Date:________________________ Age:__________

Client Name: ____Date of Birth: ________________Gender: M F

Address: ____

City: ____ State: _______________ Zip: _____________________________

Home Phone: ______________________ Cell Phone: _______________________ SSN: ______________________________

Email: ____

Employer/School:

Name: ____ Phone:__________________________________

City: ____ State: _______________ Zip: _____________________________

Emergency Contact Information:

Name: ____ Relationship to Client:___________________________

Cell Phone: ______________________________________ Email: ____

Other Family Members Attending LifeStar: [ ] N/A

Name: ____ Relationship to Client:___________________________

Cell Phone: ______________________________________ Email: ____

Previous Counseling and/or Therapeutic Treatment: [ ] N/A

Name of Provider: ____Length of Treatment: ____________________

Medications (Please include dosages if known): ____

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Who Referred You to LifeStar? Can we contact this person to thank them? [ ] Yes [ ] No

Name: ____ Phone or email: ______________________________________

You Plan to Participate in Group and/or Individual Therapy:
[ ] Group (Day and Time): ______________________ [ ] Individual [ ] Both [ ] Unsure

Name of Your LifeStar Therapist (If Known): ______________________

Responsible Party:
If you are over the age of 18, please proceed to the signature line below. If you are the parent or legal guardian of a client who is under the age of 18, please complete the following information.

Name of Parent or Legal Guardian:______________________

City: ______________________ State: __________ Zip: ______________

Cell Phone: ______________ Email Address: ______________________

I certify that the information provided is accurate to the best of my knowledge. Should any of the provided information change, I agree to update my provider as quickly as possible.

______________________________ ______________

Signature of Client (or Legal Guardian) **Date**

Additional Notes or Information We Should Know About You? Have you attended LifeStar elsewhere?

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Office Use Only:

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Electronic Payment Authorization

It is the clinic's policy to maintain up-to-date credit/debit card information **for all clients and LifeStar participants,** even if a client elects to pay by check, cash, or a third party. All card information is stored in an encrypted, 3-tier secure server in full compliance with HIPAA guidelines and regulations.

Client Name: ____Date of Birth: ___________________________

Email: ____Phone: _________________________________

Method of Payment & Card type to keep on file: [ ] Debit [ ] Credit
Please select your preferred method of payment from the list below. If a third party is paying, **it is still the client's responsibility that payment is received** from that third party. Monthly statements will be prepared and emailed electronically to the client, as well as to the responsible third party when applicable. The monthly statements can be used to submit for insurance reimbursements. **It is the client's responsibility** to submit for insurance reimbursement.

Preferred Method of Payment:
[ ] My Debit/Credit Card On File [ ] Check [ ] Cash [ ] A Third Party

I authorize the card ending in ________________________ (last four digits of the card) with the CVV code of _________________________(three digits on the back of the card**) for the following payment processing:**
[ ] All LifeStar payments and fees upon services rendered
**I understand that this form authorizes LifeStar Salt Lake to charge this card for varying session types, across multiple dates of service. By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.
[ ] Only in the event that other payment methods are delayed 60 days or more
**I understand that this form authorizes LifeStar Salt Lake to charge this card for varying session types, across multiple dates of service, only if I fail to pay by check or cash, or by a third party, within 60 days of service. By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

____ ___________________________
Card Holder Signature **Date**

Payments are processed by Therapy Partner.
Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

The section below will be destroyed once the information is securely encrypted and stored electronically

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Client Debit/Credit Card Information (Visa, MasterCard, Discover):
Card to keep on file: [ ] Debit [ ] Credit Card Type: [ ] Visa [ ] MasterCard [ ] Discover

Name on Card (if different than above):____________________________________ Expiration Date: _________________

Card Number: ____CVV Code: ________________________

Billing Information Form

Billing Information:
Same as Client Information Form: [ ] YES [ ] NO [ ] THIRD PARTY
***Please complete the information below if you selected NO or THIRD PARTY above**

Client Billing Address (If different from Client Information Form):

Address: ______________________________ **Email:** ______________________________

City: ____________________ State: __________ Zip: __________ Phone: ______________

Third Party Information (family, clergy, or anyone besides you who is paying for these services):

Amount paid by third party: [ ] 100% [ ] Partial (Please explain): ______________________

Name of Third Party or Other Responsible Party: ______________________________________

Relation to client: ____________________ Address: ______________________________

City: ______________________________ State: __________ Zip: ______________

Cell Phone: ____________________ **Email:** ______________________________

Consent For Release (If a third party is involved with either paying and/or client accountability)**:**
Invoices and monthly billing statements are sent by email. If a third party is paying for services, the billing statement will also be emailed to that third party. By signing below, you are authorizing the third party email address listed above to receive invoices and monthly statements. Upon request, other parties (spouse, family members, accountability partner, etc.) may receive billing information as well. This is highly recommended if you have an accountability partner involved in recovery. Please fill in the name(s) and emails below of those authorized to receive invoices and billing statements. All emails are secure through an authentication process. **Please be sure that the "Third Party Authorization Form" is completed and submitted as quickly as possible if a third party is responsible for payments:**

Name	Email	Client Relation

By signing below, you are authorizing LifeStar Salt Lake to send billing information to the third party email address listed at the top of this form, as well as to any additional email addresses listed above:

______________________________ ______________
Client Signature Date