Eva Tak, MFT
Changing Perspectives
4993 Golden Foothill Parkway, Suite 6, El Dorado Hills, CA 95762
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NEW CLIENT REGISTRATION FORM

First Name_____________________________MI_____Last Name____

Home Address____________________________________City__________________________State_____Zip___________

Email____Driver's Lic_____________________State_____Age__________

Home Phone(_____)__________________________Alt Phone(_____)_____________________________Gender_______

SSN#_______________________________________Date of Birth__________________________Marital Status_________

Employer/School Info____

RESPONSIBLE PARTY INFORMATION (If different from client)

First Name_____________________________MI_____Last Name____

Home Address____________________________________City__________________________State_____Zip___________

Email____Driver's Lic_____________________State_____Age__________

Home Phone(_____)__________________________Alt Phone(_____)_____________________________Gender_______

SSN#_______________________________________Date of Birth__________________________Marital Status_________

Employer/School Info____

INSURANCE INFORMATION

Insurance Company____Insurance Co Phone_________________________

Claims Address____________________________________City__________________________State______Zip__________

Group Policy #_____________________________________Subscriber ID#____

Referring Physician____Phone #_________________________________

Authorization #____________________________________Co-payment amount___________________________________

SECONDARY INSURANCE INFORMATION (If applicable)

Insurance Company____Insurance Co Phone_________________________

Claims Address____________________________________City__________________________State______Zip__________

Group Policy #_____________________________________Subscriber ID#____

Referring Physician____Phone #_________________________________

Authorization #____________________________________Co-payment amount___________________________________

AUTHORIZATIONS/RELEASES/ASSIGNMENT OF BENEFITS

I understand that I am consenting to psychotherapy treatment by provider, Eva Tak (Changing Perspectives), MA, LMFT. My signature on this document evidences that consent. I have been given the opportunity to visit her website, which provided me detailed information about her qualifications, education, fees and payment issues. If I choose to have Eva Tak (Changing Perspectives), MA, LMFT process insurance claims, I authorize the release any personal information necessary to process this insurance claim for payment. Disclosure of my personal healthcare information released includes, date of service, diagnosis, ICD-9 and CPT code. This information will only be used to process claims for payment. I understand that Eva Tak (Changing Perspectives), MA, LMFT may use outside bookkeeping resources to process claims for payment. In all cases, my personal information is confidential, but this outside company will have my name, address, and insurance information.

I/we understand I have a right to review provider's NOTICE OF PRIVACY PRACTICES (NPP) and have done so before signing this document. I have the right to receive a copy of the provider's NPP at any time by reviewing the website (www.ChangingPerspective.net), or contacting Eva Tak (Changing Perspectives), MA, LMFT at (916) 605-6629. Eva Tak (Changing Perspectives), MA, LMFT complies with the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996.

I agree to pay for sessions for which I do not show with less than 24 hours cancellation. The charge for this is $70. Provider will hold a copy of my credit card on file for this purpose. I also agree to pay (at a prorated rate of $1.70 per minute) for telephone sessions and collateral contacts that my insurance company may not cover.

I/we understand that I need to be familiar with my insurance policies coverage of mental health benefits. Working with this provider is a partnership between myself, and my insurance company. I/we further understand that provider's' office will assist in obtaining authorization from my insurance company but I/we will be ultimately responsible for payment of services rendered if my insurance does not pay for any reason. [See detailed discussion of Fees, Payment, and Insurance in the Office Policies portion of this form.]

If this account(s) become delinquent, the undersigned agrees to pay all of creditor's collection expenses, including collection agency fees of $100.00 or 30% whichever is greater, plus additional attorney's fees if the delinquent accounts are referred for litigation. In the event my invoices are not paid when due, I agree to pay twenty-five dollars every month that the invoice goes unpaid.

I authorize my insurance company to pay Eva Tak (Changing Perspectives), MA, LMFT directly the amount due on my claim for services rendered to my dependent or myself.

Patient Records: Patient agrees to accept a summary of their records, if records are requested.
In addition, I/we understand that I may stop treatment at any time with proper 24-hour notification to my therapist. My/our signature(s) here shows that I/we have read, understand, and agree to the conditions presented above.

Patient Signature____ Date___________

Spouse/Guardian Signature____Date___________

THE LAWS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) OF 1996

Please review the document entitled “Notice of Privacy Practices”, which is attached to this clipboard.

I, ____

Your Name

have read and reviewed the HIPPA laws attached, and understand my rights under this provision. If I have questions, I will discuss them with Eva Tak, MA, LMFT.

Signature____Date______________________________

Spouse/Guardian Signature____Date___________________

OFFICE POLICIES AND INFORMED CONSENT FORM

APPOINTMENTS: Appointments are scheduled for 50 or 80 minutes. This time is scheduled specifically for you, and I try to keep on schedule. If you are late, that will be time out of your scheduled appointment. It cannot be added to the end of your session.

CANCELLATIONS/NO SHOWS: A notice of 24 hours is required to cancel appointments. DO NOT email and cancellation, you must ***phone*** (916) 605-6629. This will not be covered by your insurance, and represents lost revenue for me, and lost opportunity for other patients. You will be charged $70 for cancellations with less than 24 hours notice, or for failed appointments. I will hold a copy of your credit card on file for these potential charges.

FEES, PAYMENT & INSURANCE: My fee for psychotherapy will be assessed, and discussed verbally before our first meeting. My customary fee for private pay services is $100 for individual/couple 50-minute session, or $140 for individual/couple 80-minute session. If you are seeing me under your health insurance, you should call them and ask them what the cost will be. I accept insurance and am an approved provider for several managed care programs. It is the client's responsibility to verify his/her benefits and insurance coverage. Except for Employee Assistant Programs, or Victim Witness payments, payment is expected at the time of service. I accept credit card, checks or cash. I will provide you with a 'super bill' that you can take to your insurance carrier for reimbursement. I cannot extend credit to patients. Many insurance, EAP, and Victim Witness companies require a Pre-Authorization. Some insurance companies require a referral from your physician to access mental health treatment. It is up to you to find out about these issues, I will not be allowed to discover them for you. Failure to obtain authorization may result in denial of payments, in which case the patient is responsible for the entire charge. It is always the patient's responsibility to obtain pre-authorization from their insurance company. I will assist you in ongoing authorization as needed.

If Eva Tak, MA, LMFT is NOT a preferred provider, or I am 'out of network' for your insurance company, you can still see me. I will discuss with you the charges. Your insurance company may reimburse you a portion of the fee. It is up to you to find out how much of the fee will be reimbursed by your insurance company. It is the client's responsibility to verify his/her benefits and insurance coverage. I will provide you with a 'super bill' that you can take to your insurance carrier for reimbursement. Some insurance companies require a referral from your physician to access mental health treatment. It is up to you to find out about these issues, I will not be allowed to discover them for you. Failure to obtain authorization may result in denial of reimbursement by your insurance company. It is always the patient's responsibility to obtain pre-authorization from their insurance company. If payment is denied due to lack of authorization, patient will be responsible for all charges. I cannot extend credit to patients. Telephone calls/email are considered therapy appointments, and may be charged at a 'prorated' rate of $1.70 per minute.

LOANED MATERIALS: If material from this office is borrowed, you will be responsible for the full replacement costs if the material is not returned or returned in a non-usable manner.

BILLING PRACTICES: If Eva Tak, MA, LMFT agrees to accept your insurance as payment, and bill your insurance company for therapy, you will be responsible for the co-pay at the time of service.

LIMITS TO CONFIDENTIALITY: It is the law that I must warn identifiable victims if you tell me you are going to hurt someone. I will warn them verbally, and tell police you intend to hurt them. I must report [to Child Protective Services] child abuse of any kind, either past or present. I must report [to Adult Protective Services] elder, or dependent, abuse. I will assist, and 'break confidentiality' if a patient is suicidal. Receipt of emails during course of couples counseling: I will not hold confidential email correspondence by one partner. I encourage you to discuss issues with me in session or request an individual session. I do not "hold secrets" in couples or conjoint counseling. If the issue is relevant to the therapeutic work, I will assist disclosure to partner.

EMERGENCIES: My phone has call forwarding and voice mail. I check my voicemail during my regular working hours; which is Mon.-Thurs. 8:00 AM – 6:00 PM. I am not available in the evenings or during the day on Friday, Saturday, or Sunday. There are two notable exceptions to my availability. I will be available to patients who are actively suicidal. For a crisis, that needs immediate attention such as a suicide attempt or strong suicidal intent, call 911 or go to the emergency room of the nearest hospital. If I am on vacation or gone for an extended time, I will have, colleagues cover for me. I will have their name and telephone number available on my voicemail. You can also call your insurance company's toll free number to find out about their EMERGENCY PROCEDURES or to get a referral to another approved provider if you cannot wait for me.

Office Policies and Informed Consent [Cont.]
I/we have reviewed the "Office Policies & Informed Consent Form" and "Communication [below]" has been given a chance to ask questions about it. Our/My signature(s) below signify that we are in agreement with the terms of these policies. This agreement will stay in force during length of service received from Eva Tak (Changing Perspectives), MA, LMFT.

Patient Signature____ Date____________________

Spouse/Guardian Signature____Date____________________

Therapist Signature____ Date: ___________________
Eva Tak (Changing Perspectives) MA, LMFT

COMMUNICATION AFTER HOURS or BETWEEN SESSIONS:
There will be times that I need to communicate with you. Please indicate which of the 4 methods below you prefer communication, and if it is all right for me to identify myself [as a psychotherapist] while leaving a message.

1._____ It is all right to leave a telephone message at this number revealing who you are, as a psychotherapist.

Telephone Number______________________________

2._____Please protect my privacy, and do not identify yourself as a psychotherapist when leaving a message on this number.

Telephone Number______________________________

3._____This is the best way to confidentially communicate with me in the future.__________________________________

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