INTEGRATED
Physical Therapy and Counseling
Registration Form

Name: _____ Date of Birth: _____

Address: _____
City: _____State: _____ZIP: _____

Home Phone: _____OK to leave message? Y N
Cell Phone_____OK to leave message? Y N
E-Mail _____
OK to leave message? Y N

Employer: _____Phone _____
OK to leave message for you at work? Y N

Primary Care Physician: _____Ph_____

Emerg. Contact: _____Ph_____

Please read carefully and sign below:

I am responsible for payment at the time of service, unless otherwise arranged. I have received and signed the privacy policy. Appointments cancelled with less than 24 hr. notice or no-shows will result in a $125.00 charge billed to you.

Signature_____ Date:_____

Personal Information

***Social**:*
With whom do you reside? Married? In-relationship? Children? How would you sum up your family and social life?

***Career*:**
What do you do for work? How long? Are you happy and fulfilled in your work?

Medical:
Briefly describe your health. Smoker? Addiction? Alcohol? Serious illness?

Stress Management:
Briefly describe how you manage stress. Exercise? Meditation? Fun activities?

Emotional Health:
How would you describe yourself? Depressed? Anxious? Grieving? Happy? Content?

Do you feel hopeless? Have you had suicidal thoughts? Have you ever acted on these thoughts? Have you engaged in self-harm? If so, please briefly describe.

Please briefly state your reason for seeking counseling.

Have you been in counseling/therapy before this time? If yes, please explain for how long, progress and any other information you would like to mention.

Is there anyone you would like us to be in contact with during this process? This may include family members, doctors, friends, etc. If so, we will have you fill out a separate Release of Information form.

Professional Disclosure Statement for Mental Health Counseling at Integrated Physical Therapy and Counseling

Mission: To provide counseling services in a safe, nurturing and affirming environment with an end purpose of creating a life of ease, fluidity, integration and connection to self and others. These counseling services are informed by the work of mindfulness, Sensorimotor Psychotherapy, Cognitive Behavioral Therapy, Gestalt and other approaches deemed appropriate for the treatment, that includes but is not limited to, trauma, grief, relational/attachment difficulties, anger management, depression and anxiety.

Information about therapist:

Name: Debra J. Horn (aka DJ)

Title: Counselor

Address: 609 Farmington Ave Suite 103
Hartford, CT 06105

Telephone: 860-241-1144 (press 1 for confidential message)

email: djhorn@integratedlifetherapy.com

Professional Education and Experience: I graduated from Central Connecticut Sate University in May, 2013 with an MS in Mental Health Counseling. My internships were completed at ADRC in Hartford, CT and Wheeler Clinic in Adult Services. I have run groups for Early Prevention/Treatment in Addiction Services. I also have a BS in Physical Therapy from the University of Connecticut, a diploma in Massage Therapy from the Connecticut Center of Massage Therapy. I am licensed in both Physical Therapy and Massage Therapy. I am a Certified Craniosacral Therapist through the Upledger Institute. I have over 25 years of working in the helping professions and use this vast knowledge to create individual treatment plans specific to you. My state license for Professional Counseling is #2838.

Informed Consent, Rights, Risks, and Responsibilities: Individuals and families are encouraged to share openly and honestly to enhance the opportunities for growth. This office abides by the ethics and laws regarding confidentiality. Unless you sign a Release of Information and/or the law dictates disclosure, all information will be private. The exception to this right is if I have reason to suspect danger to self or to others. In those incidences, I will need to breach confidentiality. In support of your privacy, I will not approach you outside this office should the opportunity present. This is for your benefit. You may approach me and it is important to recognize that it may threaten your privacy. Regarding contact beyond the office visit, clients are encouraged to call the office or

email when an issue arises. I will return messages within 24 hours though, most likely, sooner. Other arrangements are possible on a client to client basis. All clients are strongly encouraged to call 911 or visit the closest emergency room should an emergency arise. In the event that I am unavailable (vacation), I will have another therapist cover for me. The integration of bodywork varies from client to client. All clients will be asked to sign a separate document should this be an appropriate approach for you. It is my strongest intent to offer counseling services that are non-judgmental regarding cultural differences between self and others, which includes but is not limited to religion, ethnicity, sexual orientation, race and disability.

I have read this disclosure statement and agree to participate in mental health counseling. I have had the opportunity to ask questions and gain greater clarity.

_____ _____

Client Signature Date

_____

print name

Integrated Physical Therapy and Counseling

BILLING POLICY, RELEASE, AND AUTHORIZATION

Integrated Physical Therapy and Counseling is a fee for service practice and payment is due at the time of services rendered. We will not have any relationship with your insurance carrier and will not release any information to them without a signed Release of Information. We will make every effort to support you in filing your own claims, but cannot guarantee amount or timeliness of reimbursement. If you are unsure as to your ability to self submit claims, please contact your insurance carrier.

Signature: _____ Date: _____

Please be aware that some insurance companies require prior authorization for treatment. It is your responsibility to acquire this information as this may affect reimbursement. Insurance companies **may not** reimburse retroactively. _____

CANCELLATION POLICY

This office requires 24 hour notice on all appointments. A charge will be imposed on all appointments not cancelled with at least 24 hours or on any missed appointments. **This charge is your responsibility and cannot be charged to your insurance company**. The payment for this charge is expected before your next scheduled visit.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form acknowledges that you have received Integrated Physical Therapy and Counseling's Notice of Privacy practices.

I _____, have received the Notice of
(Patient's printed name)
Privacy Practices from Integrated Physical Therapy and Counseling.

Signature: _____ Date: _____

Revised 11/2016