Machiel P. Klerk Counseling
CLIENT REGISTRATION

CLIENT

Primary Client Name:	**Social Security #:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**
Email Address:	**Mobile Phone:**
Counseling Goals:	

PAYME

Information about the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	**Home Phone:**
Street Address:	**Work Phone:**
City, State, Zip Code:	**Mobile Phone:**

HEALTHINSURANCE

Primary Insurance:	**Policyholder Name:**
Company Address:	**Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	
Secondary Insurance:	**Policyholder Name:**
Company Address:	**Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	

INFORMEDCONSENT&SERVICECONTRACT

I understand that the goal of Machiel P. Klerk Counseling is to provide the best possible service. While I expect benefits from this treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed. A variety of methods will be used to provide relief of my symptoms, and to improve coping and problem solving skills.

I understand that the fee for the initial consultation is $130.00 and that for following sessions the fee is also $130.00 for a fifty-minute office visit. I agree to make my payment at the time of service. By paying with a credit card I understand I will be charged 2.9% transaction fee. By paying with other services such as PayPal, Venmo I will make sure that I pay the full fee, and won't charge the services fees to Machiel P. Klerk Counseling. Phone calls more than 10 minutes in length, written reports, and other professional contacts will be billed at the same rate. Clinical Psychological Assessment and related reports will be billed at a different rate, which will be discussed prior to testing. I understand that a 24-hour notice for cancellation is required. Otherwise, I will be charged full fee for the missed appointment, and I understand that this charge is not billable to my insurance. I fully understand that I am responsible to pay all charges not covered by my insurance carrier. Should my account become over 60 days delinquent, I understand that a finance charge of 1.5% per month will be added to my bill from the date of service. I will also be responsible for payment of any legal fees and/or collection costs if such services are required. I authorize the release of my identifying information to a collection agency if that should become necessary. In the event payment under this agreement is not made at the time and in the manner required, I agree to pay all costs of collection, including attorney fees, court costs, and collection agency charges and fees of up to 35% of the balance assigned. There will be a service charge of $25.00 added to my account for any returned check. I understand that Machiel Klerk will not provide therapy over email or by phone text, yet only in person or over the phone by direct voice contact. I hereby do allow Machiel Klerk to contact me on the email above or by provided phone number to send me reminders for appointments or other updates in regards to mental health, for example by emails from his website with tips, quotes and other offers and suggestions.

I understand that for mental health services to be most effective, it is essential to have these services coordinated with other health care providers. Information will only be shared in accordance with the Privacy Policies of Machiel P. Klerk Counseling. For any person or institution that is not directly related to treatment, payment of services or health care operations of Machiel P. Klerk Counseling all protected health information will be kept confidential UNLESS you sign a specific authorization. However, all health care providers are legally required to report and release the following information without specific authorization: Suspected physical/sexual abuse and/or neglect of a child or elderly person, to prevent injury to self or others, in a medical emergency to save lives, or if ordered by the court.

In the event of an emergency I will call: 1) University of Utah Neuropsychiatric Institute at 583-2500; 2) Salt Lake County Mental Health Suicide Prevention and Crisis Services at (801) 483-5444; or 3) 911 or the nearest hospital emergency room.

I have read and understand the above information and I consent to treatment under the described conditions.

PRIVACY

I have had an opportunity to review the Privacy Policies of Machiel P. Klerk Counseling.

Signature►_____ Date:_____