Jennifer Kramer Art Therapy
Mellwood Art Center
1860 Mellwood Ave.
Studio #211
Louisville, KY 40206

New Client Registration Information

Client Name:	**Nickname:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**
Email Address:	**Mobile Phone:**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about us?	**Marital Status:**

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as client)

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

_____

Client or Parent/Guardian Signature

_____

Date

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Notice of Privacy Practices

This notice describes how your private medical information may be used and disclosed, and how you can gain access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments (only applicable when billing insurance companies for services), and conduct healthcare operations. Examples of these activities include but are not limited to; review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder text messages or phone calls/voicemails, and records reviews to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal uses outlined above, unless otherwise required by law or authorized by the patient or legal representative.

2. There are some instances in which your therapist is required by law to use and disclose information to appropriate legal entities and/or social services agencies. Such instances include: If you and/or your child report information about physical or sexual abuse, if you provide information suggesting you are in danger of harming yourself or others, or when records are subpoenaed by a court of law. If such reports are made, they will be disclosed to you or your legal representative, unless disclosure increases risk of further harm.

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, and the purpose and expiration date of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are part of your medical records. Your therapist has 30 days to respond to a disclosure request and 60 days if the records is stored off site.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions, but information gathered while the restriction was in place will remain restricted by such an agreement.

9. If you wish to complain about privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. You may also contact the Kentucky Board of Professional Licensed Counselors, and/or the Kentucky Board of Professional Licensed Art Therapists. In any case, there will not be any retaliation against you or your legal representative for filing a complaint.

10. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTAND THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION.

_____ _____

Client or Legal Representative (please print) Date

_____ _____

Signature of Client or Legal Representative Date

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Cancellation, No-Show, and Late Policy

1. I understand that if I fail to give at least 24-hour notice prior to cancelling or requesting to re-schedule an appointment, I will be charged the full fee for my scheduled session: $90 for a 60 minute individual or family session, or $50 for a 120 minute group workshop session.

2. I understand that if I no-show to a scheduled session that the same fees apply (refer to number 1).

3. I understand that the therapy session will last 60-120 minutes (depending on service provided). I understand that if I arrive more than 15 minutes late to a session, that no-show/cancellation fees may apply. I also understand that if I am late to the appointment, I will still have to end the session at the allotted time.

By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from Jennifer Kramer Art Therapy.

_____
Client or Parent/Guardian Signature

_____
Date

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Consent to Disclose Information

I consent for my Art Therapist, Jennifer Kramer, to share my treatment information with the following individuals and/or organizations. I understand that information will only be shared for the purpose of continuity of care, and to ensure that I receive the best treatment possible.

Name: _____

Organization (if applicable): _____

Address: _____

Phone: _____

E-mail: _____

Can this individual or organization also share treatment information with Jennifer Kramer? YES___ NO___

Name: _____

Organization (if applicable): _____

Address: _____

Phone: _____

E-mail: _____

Can this individual or organization also share treatment information with Jennifer Kramer? YES___ NO___

Name: _____

Organization (if applicable): _____

Address: _____

Phone: _____

E-mail: _____

Can this individual or organization also share treatment information with Jennifer Kramer? YES___ NO___

_____

Client or Parent/Guardian Signature

_____

Date

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Consent to Be Photographed

By signing this form, you may choose to either consent or decline for Jennifer Kramer Art Therapy to use photographs of yourself and/or your artwork for marketing purposes. Photographs of yourself and/or your artwork may be used on social media sites, on Jennifer Kramer's professional website, or on flyers and other printed materials. Your name and other identifying information will never be shared.

Please sign the applicable line below:

1) I consent for BOTH photos of myself and of my artwork to be used for marketing purposes.

_____
Client or Parent/Guardian Signature

_____
Date

2) I consent ONLY for photos of my artwork to be used for marketing purposes.

_____
Client or Parent/Guardian Signature

_____
Date

3) I DO NOT consent for photos of myself or my artwork to be used for marketing purposes.

_____
Client or Parent/Guardian Signature

_____
Date