LIFE QUALITY RESOURCES

5613 Duraleigh Road, Suite 101
Raleigh, NC 27612
919.990.3412
919.784.0089 (fax)

NEW CLIENT REGISTRATION

Name: _____ Date of Birth: _____

Address: _____

_____

Email: _____

Phone: Cell: _____ ____ OK to leave a message?

Other: _____ ____ OK to leave a message?

I recognize that email and text messaging are not guaranteed secure means of communication.

_____ I **consent** to receive emails/text from Liza Chartier, MEd, LCMHCA / Life Quality Resources

_____ I **do not consent** to receive emails/text

Emergency Contact: _____

Relationship to Client: _____

Phone: _____

If Client is a minor:

Parent(s) / Guardian(s) Names:

_____

Contact phones if different from above:

_____

FINANCIAL RESPONSIBILITY:

*Unless other arrangements are made in advance, payment is expected at the time the service is rendered. If requested, a billing invoice will be provided that can be submitted to your insurance company for reimbursement. *Reimbursement is not guaranteed**

CANCELLATION POLICY:

Once an appointment has been made a twenty-four-hour notice of cancellation is required in order to avoid being charged for the reserved time. Any missed appointments without a twenty-four-hour prior notice of cancellation will require payment for the scheduled appointment.

_____

Signature Date

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NEW CLIENT INFORMATION

Please complete as many of the following as possible:

1. I was referred by: _____

2. I am seeking help with/for (current symptoms):

   _____

   _____

   _____

   _____

3. What other treatment interventions or methods are you currently using or have you used in the past, and what were the results? Do you have any past diagnoses or hospitalizations?

   _____

   _____

   _____

   _____

   _____

   _____

4. What is your highest hope for what you (or your child) might accomplish from your therapy, equine therapy, or biofeedback/neurofeedback?

   _____

   _____

   _____

   _____

   _____

   _____

5. Do you have any worries or concerns about therapy, equine therapy, or biofeedback/neurofeedback?

   _____

   _____

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6. Please list all medications you are currently taking, including supplements. Please indicate dosage (or provide list on separate page):_____

   _____

   _____

   _____

   *** If you are currently taking psychotropic medications, you will need to complete the Release of Information at the end of this packet with your prescribing doctor's information. ***

7. Describe disabilities/difficulties in physical function (i.e. mobility skills such as transfers, walking, wheelchair use). Include assistance required or equipment needed.

   _____

   _____

   _____

   _____

   _____

8. Please list any allergies to medications and/or environmentals.

   _____

   _____

   _____

   _____

9. What do you consider to be some of your strengths or areas in your life that are going well?

   _____

   _____

   _____

   _____

   _____

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In the section below identify if there is a current or past history of any of the following or if you have been diagnosed as such. Explain if yes.

Alcohol/Substance Use Disorder □ No □ Yes

_____

Anxiety □ No □ Yes

_____

Depression □ No □ Yes

_____

Domestic Violence/Abuse □ No □ Yes

_____

Eating Disorders □ No □ Yes

_____

Schizophrenia □ No □ Yes

_____

Suicide/ Attempts □ No □ Yes

_____

Obsessive Compulsive Behavior/OCD □ No □ Yes

_____

Acute or Chronic Pain □ No □ Yes

_____

Bi-Polar Disorder □ No □ Yes

_____

Others?

_____

Has anyone in your family had these issues? □ No □ Yes If so, please describe:

_____

_____

Is there anything else I should know about your story, history, or situation?

_____

_____

_____

_____

_____

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Consent for Treatment

I hereby give my consent for Life Quality Resources/Liza Chartier, MEd, LCMHCA, to provide services to me/my child. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

Client/Guardian: _____ Date:_____

Authorization for Emergency Medical Care

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of Life Quality Resources (LQR) or JRF Equestrian, I authorize LQR or JRF staff to:

- Secure and retain medical treatment and transportation, if needed, to the nearest medical facility;
- Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Client/Guardian Signature: _____ Date: _____

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will be invoked only if I(client) am incapacitated and unable to provide direction or, if I(guardian) am not on the premises at the time and cannot be reached immediately.

Client/Guardian Signature: _____ Date: _____

Non-Consent Plan

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property utilized by Life Quality Resources. In the event emergency medical aid/treatment is required, I wish the following procedure to take place:

_____

Client/Guardian Signature: _____ Date: _____

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Financial Agreement – Credit Card Authorization

By signing this agreement, I am authorizing Life Quality Resources/Liza Chartier to bill my credit card for professional services rendered to the "Client" that are not paid at the time of service, or for situations which fall under the late cancellation policy. I agree that I will not dispute valid charges, which may include:

• A missed session fee as outlined in Professional Disclosure document: If the client has not cancelled or rescheduled with confirmed 24 hrs. notice, as outlined in the cancellation policy, or if client does not show for an appointment and has not confirmed a cancellation.

• Telephone contact in excess of that usually associated with services, prorated at my regular hourly rate, with prior notice given before any charges are incurred. This may include phone contact in excess of 15 min. or completing forms such as medical/FMLA per your request.

• Checks that are returned will incur the check amount and an additional $30 bank fee

Credit Card Type (circle one): Visa MasterCard Discover AE Is this an HRA/HSA type cc? _____

Number: _____ Expiration Date: _____

Name as Printed on Card: _____

ZIP Code: _____

Please initial each of the following authorizing:

____ Recurring charges for services per visit outlined in fees policy. I may opt out at any time by using cash or a check

____ Cancellation fee for less than 24 hrs. confirmed notice, if a session is missed without notice, or returned check charges

____ I will not dispute legitimate charges for sessions I have received, appointments missed or without confirmation of 24 hr. notice, or charges due to a returned check

____ Balances not paid within 5 days will be charged on the credit card unless we've made other arrangements

Signature_____ Date: _____

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RELEASE OF INFORMATION

I, _____ (Client/Guardian), do hereby indicate by my signature my authorization for the release and/or sharing of information between Life Quality Resources and the following:

_____

_____

This agreement will be effective immediately and will continue until or unless I indicate in writing my termination of this authorization.

Signature_____ Date: _____

Witness _____Date: _____