DR. JOHN G.KUNA & ASSOCIATES
570.961.3361 DRJOHNGKUNA.COM 570.961.3364 (Fax)

NEW CLIENT REGISTRATION FORM

INTERNAL USE ONLY

THERAPIST: _____ **OFFICE**: _____

Dx Code: 1. _____ 2. _____ Dx. Name: _____

CLIENT INFORMATION

Today's Date: _____

Name:_____

Date of Birth: ____/_____/_____ Age: _____

Address:_____

City:_____Zip:_____

Home #_____Cell #_____Work #_____

On what number may we leave a confidential message?
☐ Home ☐ Cell ☐ Other

Do you give permission to contact you via text message at the above number(s)?
☐ Yes ☐ No

How did you hear about us? _____

INSURANCE INFORMATION

Primary Insurance: _____ ID# _____

Name of Insured: _____ DOB of Insured: ____/____/_____

Social Sec #of Insured: _____

Deductible: _____ Copay: _____

Secondary Insurance: _____ ID# _____

Name of Insured: _____ DOB of Insured: ____/____/_____

Social Sec. #of Insured: _____

EMERGENCY CONTACT INFORMATION

Notify _____ Phone: _____

Relationship to client: _____

ASSOCIATES

Sylvie Acoulon, LCSW
Karlene Albrecht, LPC
Patricia Arcaro-Krenitsky, LPC
Jennifer Buckwash, LPC
Anthony Black, LCSW
Mary-Ann Chupella, LCSW
Jeanne Decker, LCSW
Joanna Delio, LCSW
Marcy Duffy, LPC, CAADC
David Falbo, LPC
Dr. John Gibbons, LCSW
Nadine Gowarty, PsyD, LPC
Tammy Gregorowicz, PhD
Sara Grier, LCSW
Joanne Judge, LSW
Alexis KELLY, LCSW
Lori Kishel, LSW
Kristin Levandoski, LPC
Jennifer Marzzacco, LSW
William McAndrews, LSW
Michele McDermott, LCSW
Shannon McLafferty, LSW
Cortney O'Malley, LSW
Michele Pizzutti-Elliott, LPC
Keith Ripley, LPC, CADC
Theresa Schirg, LCSW
Linda Strain, LPC
Maggie Snyder, LCSW
Traci Thomas, LCSW
Jodi Weiskerger, LSW
Bethany Woznikaitis, LCSW
Philip Zuckerman, LCSW

POST-DOCTORAL RESIDENTS

Whitney Robenolt, Psy.D.

HEALTH AND MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____

- When was the date of your last physical? ____/____/_____
- Do we have your permission to contact your PCP? □ Yes □ No

Psychiatrist: _____ Phone: _____

Please list any medical problems: _____

Please list any current medications: _____

EMPLOYER & MARITAL STATUS

[We will not contact your employer without your permission.]

Company: _____
Address: _____ City: _____ Zip: _____

- ❑ I am self-em loyed
- ❑ I am unemployed
- ❑ I am retired

My Marital Status is:

- □Single
- □ Married
- □ Divorced

Partner/Spouse name: _____ Phone: _____
If the client is a child, please list Parent's names: _____
How many people live in your household? _____

ADDITIONAL INFORMATION

Are you required by a court of law to receive counseling as part of a legal proceeding?
□Yes □No

Are you interested in group therapy?
□ Yes □ No
If yes, what would you like to see as the focus of the Group Therapy to be? _____

Have you had any previous Therapy? _____.
If yes, when and where did you receive services? _____

What was helpful or unhelpful to meeting your goals previously in therapy? _____
_____

What is the nature of the concern you wish to address today? _____

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CONSENT FOR TREATMENT

I _____ give permission to _____ (name of therapist) to provide mental/behavioral health therapy for myself or my child _____. I will be treated with respect and honesty throughout treatment. I am expected to benefit from treatment, but there are no guarantees. Maximum benefits will occur with regular attendance. I understand that I may temporarily feel worse while in treatment. I will let my therapist know if this begins to happen. I can discuss with my therapist if my goals in treatment are/ are not being met.

CONFIDENTIALITY

I understand that the limits of confidentiality are: while under most circumstances communication between the client and the therapist is confidential, Pennsylvania State Law mandates the reporting of actual or suspected child or elder abuse to the appropriate agency. Also, if an individual intends to take harmful or dangerous action against another, it is the therapist's ethical duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior. Clients who may have suicidal desires are also reported and referred to the appropriate agency. Court orders may also mandate the release of confidential information. Every reasonable effort will be made to notify the client before such a compromise.

PAYMENT FOR SERVICES

Although this office will process claims by billing insurance companies, I understand that payment for insurance deductibles and co-pays are my responsibility. We do not impose any charge for no-show/late cancellation appointments, nor do we use collection agencies for outstanding late payments. By signing below, I give permission for submission to my insurance company.

TERMINATING TREATMENT

I have the right to terminate the therapeutic relationship should I desire with or without explanation. At my request, my therapist may offer referrals to other therapists/agencies that may be helpful.

NOTICE OF PRIVACY AND HIPPA

I understand my privacy and the "Protected Health Information" in the HIPPA information provided and available for reading in the waiting area. I understand billing information (i.e., diagnosis) may be shared with others who need to arrange payment for my treatment by a third party payer (insurance companies). This office uses the professional billing services of Mental Health Billing Services, LLC (c/o Rose Higgins). I understand that if I am concerned about shared information, I have the right to ask for further explanation.

Signatures on page to follow

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SIGNATURES

Client Signature: _____ Date_____

Client name Printed: _____ Date_____

For children under 14: Consent by Legal Guardian:

Signed: _____ Date_____

Printed_____ Date_____

In signing this document, I acknowledge and consent to John G. Kuna, Psy.D., Pennsylvania State Licensed Psychologist (License # PS016759), in supervising our therapy sessions with _____ (name of therapist).

I understand that Dr. Kuna will sign the claims submitted to the insurance company as the Supervising Psychologist. As such, I accept full responsibility for the charges incurred by my therapy sessions.

Client: _____ Date: _____

Witness: _____ Date: _____

4101 Birney Avenue Moosic, PA 18507
189 Market Street, Kingston, PA 18704
327 N. Washington Ave, Scranton PA 18503
1509 ½ Main Street, Scranton PA 18508
112 Warren St. Tunkhannock, PA 18657
200 Main St. Blakely, PA 18447
41 Main St. Carbondale, PA 18407
16 Luzerne Street, West Pittston, PA 18643
1011 Pennsylvania Ave Matamoras, PA 18336
301 W. Grove St., Clarks Summit, PA 18411
1605 Bloom Rd., Danville, PA 17821
35 E. Elizabeth St., Bethlehem PA 18018