REGISTRATION INFORMATION

Date:_____

Patient Name:_____
Last First Middle/Maiden

Home Address_____
City/State/Zip

Telephone(include area codes)_____
Home Work

_____
Cell email

Special Instructions for Messages:_____

DOB:_____ Age:_____ Last 4 digits of Social Security Number_____

Marital Status_____Employer/School_____

Primary Care MD:_____ Referred by:_____

Emergency Contact:_____
Name phone number(s) relationship

Person responsible for payment: _____DOB:_____

Employer of person responsible for payment:_____

Address if different than above:_____

I am responsible for full and timely payment for services that I request: _____
Signature of Responsible Party

COMPLETE BELOW ONLY IF YOU PLAN TO REQUEST REIMBURSEMENT FROM INSURANCE:

1. Check to see whether your insurance requires pre-certification(the number will be on your card)
2. Ask the secretary to make a copy of your insurance card(s).
3. Primary Insurance: _____Policy Holder _____DOB_____
4. Secondary Insurance: _____Policy Holder _____DOB:_____
5. I authorize my physician /therapist to release information about my condition and treatment to my medical insurance carrier for reimbursement. I am responsible for full and timely payment for services that I request. It is my responsibility to contact the insurance carrier promptly when payment is delayed or miscalculated.

Signature of Responsible Party:_____ Date:_____

6. I authorize the insurance company to reimburse my physician/therapist directly.

Signature of Responsible Party: _____Date:_____

Therapist Name: _____ D:_____

(OVER)

REGISTRATION INFORMATION

Name:_____ **Date:** _____

1. **Current medical Problems:**

____Diabetes	____High blood pressure	____chest pain
____Cancer	____COPD/asthma	____ sleep apnea
____Reflux	____Gastric ulcer	____Kidney disease
____Hi cholesterol	____Hepatitis	____Seizure
____Pancreatitis	____Thyroid disease	____Chronic pain

   Any other:

2. **Current prescription and non-prescription medications with dose and frequency.**

3. **Medication allergies: (include type of reaction)**

4. **Prior Mental Health Treatment, with clinician and approximate dates:**

5. **Family history of mental health and neurological problems:**

6. **Alcohol and tobacco use:**

7. **I hereby give permission to you to notify my primary care physician of my contact with you**

   (Information listed on page 1 of registration Information Form.)

Signed:_____ **Date:** _____

OFFICE POLICY

1. **PAYMENT FOR PROFESSIONAL SERVICES:**
   Payment is due at the time services are rendered. You may prefer to pay on a monthly basis. You will receive a bill at the end of each month. Please pay the full balance which appears on the bill by the end of each month; past due balances may lead to collection. Any other payment arrangements should be discussed with your clinician.
2. **INSURANCE:**
   It is most likely that your clinician will be an out of network provider for any insurance plan that you might carry. The suite secretary can usually answer questions about this for your specific situation. If your insurance plan requires pre-approval before your first appointment please contact them to obtain this before your first session.

   Upon request our office will file your insurance claim forms for you on a monthly basis. The amount of reimbursement from the insurance company will depend upon your policy. Although we try to be helpful in any way that we can, we are not responsible for follow up of your insurance claims. Please contact your insurance company directly concerning problems that may arise regarding reimbursement.
3. **APPOINTMENT CANCELLATION POLICY:**
   If for any reason you are unable to keep a scheduled appointment, you are responsible for calling to cancel. Unless you cancel at least 24 hours prior to the scheduled appointment time you will be charged for the missed appointment. These charges are not covered by insurance.
4. **COVERAGE:**
   After hours, weekends and during vacations your clinician or their covering counterpart will be available to you for emergencies by calling the office telephone number and requesting the answering service. We request that all issues that can be attended to during business hours be handled during office hours. All clinicians have a voice mail box to be used for non-emergent messages.
5. **LENGTH OF SESSIONS:**
   Each session has a designated time limit. If you are late for a session, that time is lost from your session.
6. **CONFIDENTIALITY:**
   Maintaining your confidentiality is a very high priority. Only in instances in which your life or the life of another is at risk does your clinician have the right to break this without your consent. Your clinician may discuss your treatment with the doctor/therapist who will be covering for them when they are away to be sure that your needs are met.

   Please feel free to discuss any questions related to these policies with your treating clinician.

_____ _____ _____

Signature of patient **Signature of responsible party** **Date**