Patient Registration

Client's Name_____Date of Birth_____

Email address_____Age_____
Gender: [ ]Male [ ]Female Marital Status: [ ]Single [ ]Married [ ]Other_____

Mailing Address_____
City_____State_____Zip Code_____
Home Phone_____ Cell Phone_____

Employer Name_____Phone_____

Gross Family Income_____
Education Level_____

Emergency Contact_____Phone_____
Reason for seeking services:_____
_____
Medications (include over the counter drugs and supplements):_____
_____

Family Members (Spouse, Children)

Name	Age	Grade/Occupation	Relationship	Living at Home?
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No

Client's Family of Origin (Mother, Father, Brothers, Sisters)

Name	Age	Grade/Occupation	Relationship	Living at Home?
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No

Responsible Party (if other than patient):
Name_____Relationship_____
Social Security Number_____Date of Birth_____
Insurance Company Name_____Phone_____

How Did You Find Us?
[ ]Friend/Family [ ]Internet [ ]Physician Referral [ ]Other_____

PCP Physician's
Name_____Phone_____Fax_____
Address_____
[ ] Permission to contact and/or coordinate services as needed with my PCP.
Signature_____Date_____

Disclosures and HIPPA

Appointment Policy

____If it is necessary to change your appointment, our office requires a 48 hour notice.
____Rescheduling of an appointment with less than 48 hours prior notice will be considered inadequate time for our office to place a patient in your reserved time slot.
____Failure to provide 48 hours notice WILL result in a charge for the standard fee for our service, the full fee is $150.00 plus tax.
____If we can both find another time that week available, the therapist reserves the right to move you to a different time slot that week instead of charging the full fee.
____ Please call if you have a cold or communicable disease and we will discuss options. The office accepts messages 24/7.
____ Cancellations via email will not be accepted. They must be with voicemail or phone.
____I understand any fees will be charged to my credit card.

Signature_____Date_____

Filing of Insurance

____Total payment is expected at the time of the service.
____ Our office will bill your primary insurance. As a patient, you agree and guarantee to be responsible for and settle any remaining account balance including, but not limited to: co-pays, deductibles, and amounts denied by insurance.
____By signing this agreement, the patient or responsible party agrees to be responsible for all fees and understands that any remaining fees due will be charge to the credit card on file.
____I understand that final sessions must be face to face and there is a wrap-up session required upon completion of therapy.
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Signature_____Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have read a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current policy is available upon request.

Signature_____Date_____