

Client Registration

Today's Date: _____
Client's Full Name: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____
May we contact you at these numbers? _____ Birthdate: _____
Sex: _____ Employer: _____ Phone Number: _____
Student?: (yes/no) School: _____ College: _____
Family Physician: _____ Referred by: _____
Person to contact in Emergency: _____ Phone: _____

INSURED/RESPONSIBLE PARTY INFORMATION

Please complete the following regardless of insurance coverage.

Full name Primary Insured: _____ DOB: _____ Relationship: _____
Occupation: _____ Home Address: _____
Phone: _____ Employer and Address: _____
Phone: _____ State: _____
Full name of Spouse: _____ DOB: _____
Spouse's Employer: _____ Phone: _____
Insured's Primary Ins. Co.: _____ I.D. No.: _____ Group No.: _____
Insurance Company phone #: _____ Secondary Ins. Co.: No yes;
Company: _____ Policy No: _____
Job Related Injury-Workmens Comp. Co.: No Yes; Company _____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions
2. I authorize the release of information to my insurance company(s)
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Name: _____

Signature: _____ Date: _____

- **It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time services provided. If you are unsure of your insurance coverage, you are responsible for paying the full amount at time of service until your insurance coverage is established.**
- **There will be a \$25.00 service charge for all returned checks.**
- **In the event your account goes to collections, there will be a 20% collection fee added to your balance.**
- **There is a 24 hours in advance cancellation policy to avoid being charged a \$50.00 fee.**

I agree to these terms and conditions

Signature: _____ Date: _____

Limits On Patient Confidentiality

We are required to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or others.
 2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
 3. Your therapist was appointed by the courts to evaluate you.
 4. Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.
 5. Your contact is one in which your psychotherapist must file a report to a public employer or as to information required to be recorded in a public office, if such report or record is open to public inspection.
 6. You are under the age of 16 years and are the victim of a crime.
 7. You are a minor and your psychotherapist reasonable suspects you are the victim of child abuse.
 8. You are a person over the age of 65 and your psychotherapist believes you are the victim of physical abuse. Your therapist may disclose information if you are the victim of emotional abuse.
 9. Your contact is for the purpose of establishing your competence.
 10. You die and the communication is important to decide an issue concerning a deed or conveyance will or other writing executed by you affecting as interest in property.
 11. You file suit against you therapist for breach of duty or your therapist files suit against you.
 12. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
 13. You waive your rights to privilege or give consent to limited disclosure by your therapist
 14. Your insurance company paying for services has the right to review all records.
- If you have any questions about these limitations, please discuss them with your therapist.

Signature: _____ Date: _____

Consent for Treatment

I am consenting to my (or my dependent) receiving outpatient mental health treatment.

Signature: _____ Date: _____

SELF ASSESSMENT

What is happening in your life which resulted in this appointment? _____

What would you like to see accomplished in therapy? _____

CHIEF COMPLAINT CHECKLIST (CHECK ALL THAT APPLY)

- | | |
|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feeling that you are not real |
| <input type="checkbox"/> Low Energy | <input type="checkbox"/> Feeling that things around you are not real |
| <input type="checkbox"/> Low Self-Esteem | <input type="checkbox"/> Lose track of time |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Unpleasant thoughts won't go away |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Anger/frustration |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Easily agitated/annoyed |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Defies rules |
| <input type="checkbox"/> Sleep Disturbance (more/less) | <input type="checkbox"/> Blames others |
| <input type="checkbox"/> Appetite Disturbance (more/less) | <input type="checkbox"/> Argues |
| <input type="checkbox"/> Thoughts of hurting yourself | <input type="checkbox"/> Excessive use of drugs and/or alcohol |
| <input type="checkbox"/> Thoughts of hurting someone | <input type="checkbox"/> Excessive use of prescription medication |
| <input type="checkbox"/> Isolation/social withdrawal | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Sadness/loss | <input type="checkbox"/> Physical abuse issues |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Sexual abuse issues |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Spousal abuse issues |
| <input type="checkbox"/> Heart pounding/racing | <input type="checkbox"/> Other problems/symptoms: |
| <input type="checkbox"/> Chest pain | _____ |
| <input type="checkbox"/> Trembling/shaking | _____ |
| <input type="checkbox"/> Sweating | _____ |
| <input type="checkbox"/> Chills/hot flashes | _____ |
| <input type="checkbox"/> Tingling/numbing | _____ |
| <input type="checkbox"/> Fear of dying | _____ |
| <input type="checkbox"/> Fear of going crazy | _____ |
| <input type="checkbox"/> Nausea | _____ |
| <input type="checkbox"/> Phobias | |
| <input type="checkbox"/> Obsessions/Compulsive behavior | |
| <input type="checkbox"/> Thoughts racing | |
| <input type="checkbox"/> Can't hold onto an idea | |
| <input type="checkbox"/> Easily agitate | |
| <input type="checkbox"/> Excessive behaviors (spending, gambling) | |
| <input type="checkbox"/> Delusions/hallucinations | |
| <input type="checkbox"/> Not thinking clearly/confusion | |

Previous outpatient therapy? Yes No, with _____

What was accomplished? _____

Medications, list: _____

Previous hospitalization? Yes No Number of hospitalizations _____

If yes, when? _____