PATIENT REGISTRATION

PATIENT

Name ____ Date of Birth___________________
(Last) (First) (MI) (Month) (Day) (Year)

Address ____
(Street/Box No.) (City, State) (Zip code)

Social Security Number _____________________________ Home Phone _________________________

Cell Phone __________________________________ Email ______________________________________

EMERGENCY CONTACT PERSON

Name _____________________________________ Phone _____________________________________

OTHERS IN FAMILY

Name ___________________________________ DOB ___________ Phone ________________________
Name ___________________________________ DOB ___________ Phone ________________________
Name ___________________________________ DOB ___________ Phone ________________________
Name ___________________________________ DOB ___________ Phone ________________________

RESPONSIBLE PARTY

Name ____________________________________ Relationship __________________________________

Address ____
(Street/Box No.) (City, State) (Zip code)

SSN ___________________________ DOB ______________ Home Phone __________________________

EMPLOYER (S)

Patient Employed by _______________________________________ How Long _____________________

Address ____ Phone ________________________

Spouse Employed By _______________________________________ How Long _____________________

Address ____ Phone ________________________

REFERRED BY (Please indicate if referred through your employee Assistance Program and what the EAP company name is)

Name ____ Phone __________________________________

Address ____

INSURANCE (We will take a copy of your insurance card)

1. Simply stated, what brings you to our office?

____

____

____

2. Is your condition related to (Please check the appropriate box) ___ Employment ___ Auto Accident ___ Other Accident

3. How is your general health? (Please circle)

Rheumatic Fever Diabetes Anemia Sinus Problems Heart Problems Arthritis

Hepatitis/Liver Disease Asthma/Hay Fever High Blood Pressure Kidney Problems

Mouth Ulcers Stomach Ulcers Low Blood Pressure Glaucoma Circulatory Problems

Allergies to Medicine Epilepsy Emphysema Tuberculosis Nervous Problems

Stroke Cancer/Tumor Allergies to Anesthetics Hormone Disorder Radiation Treatment

Psychiatric Care Other ____

5. Please list any medications you are currently taking and for what purpose:

____

____

____

6. Do you have any allergies? Please list:

____

____

7. Please list any hospitalizations or operations:

____

____

____

8. Have you or are you currently using any illicit drugs? (Please circle) Yes/No   If so, please list:

____

____

9. Have you ever received psychological or counseling services before? (Please circle) Yes/No
If so, please give dates and simple statement of problem:

____

____

10. Is there a history of medical or psychiatric illness in your family? (Please circle) Yes/No
If yes, give relationship or family member to you and type of illness or problem

____

____

____

Patient Name: ________________________________ Date of birth: ____________________

Owens & Associates Counseling & Therapy Center, LLC/Primary Care Physician Consent Form for Coordinating Care

I, _________________________, authorize/do not authorize __________________________,
(Circle One)
My mental health provider and _______________________, ___________________________
(PCP Name) (PCP address & phone)

to exchange information regarding my treatment and my medical healthcare for coordination of care purposes as may be necessary. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above noted provider. I also understand it is my responsibility to notify my provider if I choose to change my Primary Care Physician.

____________________________________ __________________________

I Authorize communication between my Provider and my PCP (Patient Signature)

Date

____________________________________ __________________________

I DO NOT Authorize communication between my Provider and my PCP (Patient Signature)

Date

11. Name of Primary Care
Physician Name: ____

Address:____

Phone: ___________________________________ Fax: ______________________________

12. Are you being treated by a physician now? (Please Circle) Yes/No
If yes, please give reason for treatment

____
____
____

I CERTIFY THAT THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

____ ___________________________________
Signature of patient, or parent/guardian if a minor Date

CANCELLATION POLICY

I understand that should I, at any time during the course of my treatment, need to cancel or change an appointment time, I will need to do it 24 hours in advance of the appointment time or be charged for the hour, since it has been reserved for me and without sufficient notice is unavailable for another client.
Please note: This is not a charge which can be submitted to insurance.

Signature of patient or parent/guardian if a minor:
____Date:
____

I understand that although my insurance may pay a portion of the cost of the professional services received in this office, I am ultimately responsible for complete payment of the charges. Because of my responsibility and because I realize that prompt payment allows the office to keep it's fees as low as possible, I will pay by the session or follow another payment plan negotiated by the therapist.

Responsible Party: __________________________________ ___________________________
(Signature) (Date)

FEES

Initial Diagnostic Assessment (45 – 50 min): 90791 - $185.00
Individual Therapy (35 – 45 min): 90834 - $110.00
Individual Therapy (46+ min): 90837 - $150.00
Family/Couples Therapy (35 – 50 min): 90847 - $125.00
Individual Therapy (16 – 34 min): 90832 - $70.00
*Correspondence, Letters, Reports: Fee determined by therapist at conclusion of report

**This can include any phone calls made for the purpose of exchanging information and coordinating a client's care. (i.e. child's teachers, school counselor, social worker, medical doctor, attorney etc.) Health care companies do not usually consider this a reimbursable expense.*

Signature of responsible party ___________________________________ Date _______________

MUST BE COMPLETED AT TIME OF INTAKE

Please provide the following credit card information. It is understood that despite your means of payment, your credit card account will be charged for any outstanding balance.

THIS INFORMATION MUST BE COMPLETED. ALL INFORMATION IS KEPT CONFIDENTIAL AND WILL ONLY BE USED TO CLEAR UP ANY OUTSTANDING BALANCE.

Account Number ____ Expiration Date ___________

V-Code (3 digits) ______________ Name as it appears in card ______________________________

Signature ____

Your credit card will only be charged if there has been no activity on your account for two months and no response to statements sent monthly.

NOTICE OF PRIVACY PRACTICES

This notice describes how private health information about you may be used and disclosed and how you can access this information. If you have any questions, please contact the Privacy Officer at Owens & Associates Counseling & Therapy Center, LLC. All written requests and appeals should be submitted to the Privacy Officer.

Who will follow this notice?

Owens & Associates Counseling & Therapy Center, LLC provides mental health counseling services to our clients through the services of mental health professionals. The information privacy practices in this notice will be followed by all mental health professionals who treat you at any location and all employees, staff, or others with whom we share information.

Our pledge to you.

We understand that health information about you is personal. We are committed to protecting the privacy of your health information. At Owens & Associates Counseling & Therapy Center, LLC a record of the care and services you receive is maintained in order to ensure the provision of quality care and to comply with legal requirements. This notice applies to all records of your care that we maintain, whether created by our facility staff or those received from other health care providers. The law requires us to:

1. Keep health information about you private.
2. Give you this notice of our legal duties and privacy practices with respect to your health information.
3. Follow the terms of notice currently in effect.

Changes to this notice:

Owens & Associates Counseling & Therapy Center, LLC may change privacy policies and this notice at any time. Changes will apply to health information we already hold as well as new information held after the change occurs. Before a policy change affecting the privacy of your health is made, Owens & Associates Counseling & Therapy Center, LLC will change this notice and post the new notice in all staff offices and on our website at www.owenscounseling.com. You may receive a copy of the notice at any time. You will be offered a copy of the current notice upon enrollment for services.

How we may use and disclose information about you:

1. Owens & Associates Counseling & Therapy Center, LLC may use and disclose health information about you for treatment, to obtain payment for treatment, and to support our health care operations.
2. Owens & Associates Counseling & Therapy Center, LLC may use or disclose medical information about you without your prior authorization for several reasons. Subject to certain requirements, we may give out health information for public health services, abuse or neglect reporting, health oversight audits or inspections, research studies, coroner or medical examiner reviews, worker's compensation purposes, governmental functions, and emergencies. We may also disclose health information when required by law and for law enforcement purposes and specific circumstances or in response to valid judicial or administrative orders. We may also disclose health information if you are a member of the armed forces or foreign military personnel or if you are an inmate or under custody of a law enforcement official.
3. Owens & Associates Counseling & Therapy Center, LLC may contact you for appointment reminders or aftercare follow up, to tell you about or recommend possible treatment options, alternatives, health related benefits or services that may be of interest to you.
4. Owens & Associates Counseling & Therapy Center, LLC may disclose your health information to our business, each of whom has entered into a written contract with us regarding the privacy of your health information.

Other uses of health information:

In any other situations not covered by this notice, Owens & Associates Counseling & Therapy Center, LLC will ask for your written authorization before using or disclosing health information about you. If you choose to authorize use or

disclosure, you can later revoke that authorization by notifying us in writing. However, we cannot take back any disclosures already made with your permission. Owens & Associates Counseling & Therapy Center, LLC will keep a record of all disclosures made.

Your rights regarding health information about you:

1. In most cases you have a right to look at or receive a copy of health information that we use to make decisions about you care. A written request is required. If you request copies, we may charge a fee for the cost of copying, mailing, and administrative handling. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
2. If you believe that information in your record is incorrect of if important information about you is missing, you have a right to request we correct or amend the records, by submitting a request in writing that provides your reason for requesting the correction or amendment. Owens & Associates Counseling & Therapy Center, LLC may deny your request to correct or amend a record if information was not created by us, if it is not part of your health information maintained by us, if it is not part of the health information that you have a right to review, of if we determine the record is accurate and complete. You may appeal, in writing, a decision by us not correct or amend your record.
3. You have a right to a list of certain instances where we have disclosed health information about you, when you submit a written request. The request must state the time period desired for accounting. You may receive the list in paper or electronic form. The first disclosure list requested in a twelve month period is free. Other requests within the same twelve month period will be charged according to our cost of producing the list. We will inform of the fee before you incur any costs.
4. You have the right to request that health information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you. Owens & Associates Counseling & Therapy Center, LLC will not ask the reason for your request and will accommodate all reasonable requests.
5. You may request, in writing, a limit on the health information we use or disclose about you for your treatment, payment, or healthcare operations. You may request that we limit the health information disclosed about you or someone who is involved in your care. In your request you must state what information you wish to limit; whether you want to limit our use, disclosure or both; and to whom you want to limit the information. Owens & Associates Counseling & Therapy Center, LLC will consider your request but are not legally required to accept it. We will inform you of our decision to your request.

Complaints:

If you are concerned that your privacy rights may have been violated or if you disagree with a decision we made about access to your records, you may contact our Privacy Officer. Additionally, you may send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights. Under no circumstance will you be penalized or retaliated against for filing a complaint.

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________ acknowledge that I have received a copy of the Notice of Privacy Practices snd Rights for Owens & Associates Counseling & Therapy Center, LLC. I understand that I may contact the designated Privacy Officer at Owens & Associates Counseling & Therapy Center, LLC if I feel that my privacy has been violated.

Client Signature: ____ Date: ____________________

Guardian: ____ Date: ____________________

CONSENT FOR TREATMENT

1. My signature affirms that it has been disclosed to me in clear, non-technical language the nature of the assessment and treatment planning process. This disclosure included the risks and benefits of treatment, the alternatives available, and the risks of no treatment. This disclosure was understood by me and enabled me to make an informed consent to this treatment process. I understand that I may revoke this consent at any time. If consent is revoked, a new treatment may be developed or Owens & Associates, Counseling & Therapy Center, LLC will make a reasonable effort to provide a list of more appropriate or more acceptable treatment options through other mental health service providers.
2. I agree to pay the billed fee for all services provided including Individual, Couple, & Family Counseling and Therapy, Group Therapy and Group Counseling services, Case Management Services, and Client Centered Consultation Services. Intake session may be billed at a higher rate. (Case management and client centered consultation services may include but are not limited to the following: contact with other service providers, contact with school personnel, contact with law enforcement agencies, contact with court personnel, and contact with other family members. Case management services may include but are not limited to face to face contact, telephone contact, and contact by other electronic media, and letter writing.
3. I understand that I must provide a 24 hour notice for all cancelled appointments. I agree to pay in full for all late canceled appointments and all scheduled appointments that I fail to attend.
4. I agree to pay any balance due that is not paid for by insurance or any third party payer.
5. All fees are due at time of service. Fees may be paid by cash, check, or credit card. For your convenience Owens & Associates Counseling & Therapy Center, LLC is equipped to process Visa, MasterCard, and Discover as well as your personal checks. A $35.00 NSF charge will be assessed to all accounts as applicable.
6. I understand that if all fees are not paid in full at the time of service, I will be billed. If balance remains unpaid after 60 days, my account will be sent to collections. If my account is sent to phase 1 of the collections process, I will be responsible for an additional collections fee of $25.00. If my account remains unpaid and is sent to phase 2 of the collections process I will be responsible for my current balance plus an additional 50% collections fee. Example: $150 (current balance) + $75 (half of balance) = $225 (New phase 2 collections balance).

Client's Name: ____

Client's Signature: ____

Guardian: ____

Revised 7.15.15

CLIENT COPY

CONSENT FOR TREATMENT

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION TO INSURANCE COMPANY

Insurance Company: ____

Phone number: ____

Address: ____

Employer Name: ____

Phone Number: ____

Address: ____

Policy Number: ____

Social Security Number: ____

I.D. Number: ____

Group Number: ____

1. I give Owens & Associates Counseling & Therapy Center, LLC permission to release my name, date of birth, mental health diagnosis, treatment pan, date of service, and service type received from Owens & Associates Counseling & Therapy Center, LLC only as required by my insurance company in order to process my claim.
2. I have been told that I have a right to review the information to be release. I understand that signing this form is not a required condition of receiving services from Owens & Associates Counseling & Therapy Center, LLC, and that I can withdraw this permission at any time.
3. I understand that Owens & Associates Counseling & Therapy Center, LLC will submit a mental health diagnosis (from the Diagnostic and Statistical Manuel, 5th edition TR) for the person identified as the patient on the insurance claim form.

4. This authorization to release information expires on: ____

Client Signature: ____ Date: ________________

Parent/Guardian: ____ Date: ________________

Witness: ____ Date: _______________