ALASE Center for Enrichment II

Helping to Heal Minds, Hearts and Souls

Face Sheet/ Patient Registration Form

PATIENT INFORMATION

Name: _____ DOB: ____/____/_____ Gender: _____
Address: _____ Town/City: _____
State: _____ Zip Code: _____ Home Phone #: _____
Cell/ Work Phone #: _____
Guardian: _____ Address: _____ Phone: _____
Medicaid Number: _____ Medicare Number: _____
Employer/ School Name: _____ Occupation/ Grade: _____
Employer/ School Address: _____ Annual Salary: _____

DEMOGRAPHIC INFORMATION:

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Pregnant ☐ Yes ☐ No
Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino
Race ☐ Black or African American ☐ White ☐ Asian
☐ American Indian or Alaska Native ☐ Other: _____
Number of Arrests in last 30 days: _____ Education Level: Highest Grade Completed in School: _____
Living Arrangement: ☐ Home with Family ☐ Group Home / Number of People that Live in Your Home: _____
Military Service ☐ None ☐ Self ☐ Parent ☐ Spouse Rank and War if Applicable: _____
How did you hear about our Clinic: ☐ Internet ☐ Word of Mouth ☐ Physician ☐ Other Professional Referral

EMERGENCY CONTACT INFORMATION:

Name: _____ Home Phone: _____ Relationship: _____
Cell/ Work Phone: _____ Address: _____

PRIMARY CARE PHYSICIAN INFORMATION:

Name: _____ Address: _____
Town/City: _____ State: _____ Zip Code: _____
Phone #: _____

INSURANCE INFORMATION:

Insurance Company: _____ Address: _____
Group Name: _____ Group #: _____
Policy Holder's Name: _____ Policy Holder's DOB: ____/____/_____
Policy Holder's Social Security #: _____/_____/_____ Policy Holder's Relationship: _____

CONSENT TO THE USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS:

I understand that my health information may be used and disclosed by Alase Center for Enrichment to carry out treatment, to obtain payment and to conduct healthcare operations. I have read and understand the Notice of Privacy Policy, provided by Alase Center for Enrichment, which gives a more complete description of uses and disclosures of health information. I hereby grant the medical personnel of Alase Center for Enrichment permission to release health information acquired in the course of my examination and treatment to the appropriate parties, with all due discretion, when necessary for treatment, payment, healthcare operations and emergency purposes. I understand that the medical personnel at Alase Center for Enrichment will communicate, on a regular basis, with other treating health care providers. All records are kept confidential and shared only with pertinent personnel involved. I understand that I have the right to request restrictions on how health information may be used or disclosed, but that the provider designated is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the provider has taken action in reliance on the consent. I agree that this consent shall be valid until rescinded in writing or replaced in writing by one at a later date.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Marital and Couple Therapy Intake Form

First Name: _____ Last Name: _____

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

First Name: _____ Last Name: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

Best method(s) of contact, if needed?

Telephone No. (Main): (____) ____ - _____ (Other): (____) ____ - _____

E-mail Address: _____ @ _____

Highest level of education completed:

☐ high school diploma/GED ☐ some college/technical certificate ☐ college graduate

☐ professional training ☐ other _____

In the case of an emergency, who should we contact? _____

Relation to client(s): _____ Telephone No.: (____) ____ - _____

Relationship Status (please check one):

☐ married

☐ living together

☐ separated

Length of time married/ partnered: _____ months _____ years

Are there children living with you? ☐ yes or ☐ no

If yes, please list their name and age:

Name	Age

6015 Fayetteville Road, Suite #114, Durham, NC 27713
Office: (919) 957-7357 www.alase.net Fax: (919) 957-9539

Intake Questionnaire

Client's Name: _____ Date: _____

Reason(s) for Seeking Services: _____

_____

How long have you been experiencing these problems? _____

Past Diagnoses: _____

_____

Current Medications (include dosage and frequency): _____

_____

Previous Outpatient Therapy: _____

_____

Previous Inpatient Treatment: _____

_____

Stressors affecting you or your family:

○ Death	○ Employment Change	○ Sexual Abuse
○ Birth	○ School	○ Chronic Illness
○ Marriage	○ Stepchildren	○ Medical
○ Divorce/Separation	○ Substance Abuse	
○ Recent Move	○ Physical Abuse	

What are the five most important things in life to you?

1. _____
2. _____
3. _____
4. _____
5. _____

What are your goals for participating in psychotherapy? :

_____

_____

_____

Are there children that live outside the home? If yes, please list their name and age:

Name	Age

Reasons for Therapy

What are the major problems? _____

How long have you had this problem? _____

Has there been a time that you have had this similar problem? ☐ yes or ☐ no

If yes, please explain? _____

In the past what has been done to resolve this problem? _____

Why are you seeking help now? _____

What are something's you would like to see happen as a result of therapy? _____

What are some of the strengths of your marriage? _____

Medical Records

Have you ever received counseling in the past? ☐ yes or ☐ no

If yes, when and by whom? _____

_____

If there are any physical illnesses or symptoms present, please list them? _____

_____

_____

_____

Physicians/ Psychiatrist's Name (s) and Telephone No. (s):

Name: _____ Telephone No.: (____) ____ - _____

Name: _____ Telephone No.: (____) ____ - _____

Name: _____ Telephone No.: (____) ____ - _____

If there are current medications that are being taken, please list them:

Medication	Date Prescribed	For how long?

Have either of you received help for drugs or alcohol dependency? ☐ yes or ☐ no

Who? _____ When? _____
For? _____ Where? _____

Have either of you been hospitalized for emotional/ psychiatric reason? ☐ yes or ☐ no

Who? _____ When? _____
For? _____ Where? _____

What are your goals for your marriage while they are coming to Alase Center for Enrichment? ____

_____

_____

_____

If there is any additional information you would like the Dr. Smith to know how please list it below:

_____

_____

_____

_____

Insurance Information

Client Name: _____ Authorization No.:_____

Primary/Secondary Insurance Company Name: _____
(Circle)

Address of Insurance Company: _____
_____

Contact Name & Phone Number: _____

Name of Insured & Relationship to Client: _____

Birth Date of Insured: ____ / ____ / ____ Gender of Insured: Male / Female

Effective Date of Policy: ____ / ____ / ____

Policy No.: _____ Group No.: _____

Employer of Insured: _____

Plan/Program: _____

Please check one and sign below:

_____ I would like for Alase Center for Enrichment to assist in filing my insurance claim using "In Network or Out of Network" options. I authorize Alase Center for Enrichment to communicate with my insurance carrier regarding treatment. I understand that Alase Center for Enrichment will follow HIPAA guidelines regarding confidentiality and that only necessary information will be provided when requested by my insurance company. I also understand that I will not be notified of such communication unless specifically requested by me in writing.

_____ I will either file independently or will not be using insurance benefits at this time.

_____ ____ / ____ / ____
Client, Parent or Guardian Signature Date

This is strictly a confidential client medical record. Redisclosure or transfer is expressly prohibited by law.
The signature of a parent or legal guardian is required if the client is under 18 years of age or legal incompetent.

Additional Insurance Information

Client Name: _____ Authorization No.:_____

Primary/Secondary Insurance Company Name: _____
(Circle)

Address of Insurance Company: _____
_____

Contact Name & Phone Number: _____

Name of Insured & Relationship to Client: _____

Birth Date of Insured: ____ / ____ / ____ Gender of Insured: Male / Female

Effective Date of Policy: ____ / ____ / ____

Policy No.: _____ Group No.: _____

Employer of Insured: _____

Plan/Program: _____

Please check one and sign below:

_____ I would like for Alase Center for Enrichment to assist in filing my insurance claim using "In Network or Out of Network" options. I authorize Alase Center for Enrichment to communicate with my insurance carrier regarding treatment. I understand that Alase Center for Enrichment will follow HIPAA guidelines regarding confidentiality and that only necessary information will be provided when requested by my insurance company. I also understand that I will not be notified of such communication unless specifically requested by me in writing.

_____ I will either file independently or will not be using insurance benefits at this time.

_____ ____ / ____ / ____
Client, Parent or Guardian Signature Date

This is strictly a confidential client medical record. Redisclosure or transfer is expressly prohibited by law.
The signature of a parent or legal guardian is required if the client is under 18 years of age or legal incompetent.

POLICIES & PROCEDURES

This contract contains information about our services and the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a new federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. A Notice of Privacy Practices (NPP) is attached to this contract and explains HIPAA in greater detail. The law requires that we obtain your signature acknowledging that we provided you with this information. Signing this agreement also represents an agreement between us. You may revoke this contract in writing at any time which will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process claims; or if you have not satisfied any financial obligations you have incurred.

APPOINTMENTS

Your appointment represents time reserved for you. As schedule permits, we will work out the most convenient time for you for these appointments. **We reserve the right to charge $50.00 for all cancellations made less than 24 hours in advance.** Please help us serve you better by keeping scheduled appointments. We provide an answering machine during non-business hours, for your convenience in leaving a message. Simply call (919) 957-7357 and leave a confidential voice message. **We also reserve the right to reschedule your appointment if you arrive more than fifteen minutes late, dependent upon the schedule that day.**

PAYMENT OF FEES

Payment is to be made in full at time of service with the exception of co-payments when applicable. We accept cash, check or credit/debit card. Payment of any unpaid balance on your account must be received in full before the close of the month. Unpaid balances older than 60 days will be subject to an interest charge of 1.5% per month (15% annually). Payments are non- refundable. You will be liable for all cost if your account default and require the use of a collection agency. In addition, you will be liable for all other cost incurred in their service including, but not limited to, corporation fees, attorney's fees and all court related expense. Services maybe interrupted until payment is made.

INSURANCE/THIRD PARTY/MANAGED CARE

We highly recommend that you verify your insurance benefits and we will be happy to assist you in this. As a courtesy to you, will file insurance claims on your behalf. You receive a monthly statement showing your balance and indicating whether insurance has been filed out. Please understand that you are responsible for any balances not covered by your insurance. You are also responsible for all deductibles, co-payments, and estimated amounts not covered by your insurance company are due at the time services are rendered. Your insurance policy is a contract between you and your insurance carrier; we are not the party to that contract. It is your responsibility to obtain authorization to for the initial visit.

CONTACTING YOUR THERAPIST

Due to the work schedule, therapists are often not immediately available by telephone. While usually in the office between 9 AM and 5 PM, they will not answer the phone when with a client. When unavailable, telephones are answered by voice mail or by the front office staff. We will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please leave times when you will be available.

PROFESSIONAL RECORDS

The laws and standards of the helping profession require that we keep PHI about you in your Medical Record. Except in circumstances that involve danger to yourself and/or others, or the record makes reference to another person and we believe that access is likely to cause harm to such other person, you may examine and/or receive a copy of your Medical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in our presence or have them forwarded to another professional so you can discuss the contents. We charge a copying fee per page. If we refuse your request for access to records you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Medical Records and disclosures of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your Medical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this contract, the attached NPP form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

READ CAREFULLY AND COMPLETE

I have read, understand and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

I agree to pay each visit in full and have Alase Center for Enrichment (ACE) file my insurance.

_____ _____

Signature of Client or Responsible Party | Office Staff or Doctor's Signature

_____ _____

Signature of Client or Responsible Party | Office Staff or Doctor's Signature

Date___/___/____ Date___/___/____

Please feel free to direct any questions to the front office staff or your therapist. Your understanding of this contract is important to us and we are happy to discuss any or all of these conditions with you at any time. We look forward to serving you and your family.

The signature of a parent or legal guardian is required if the client is under 18 years of age or legal incompetent.

Billing Information:

I authorize the release of information to my insurance company relevant to the processing of insurance claims for myself of my dependent.

_____ ___ / ___ / ___
Client, Patient or Guardian Signature Date

_____ ___ / ___ / ___
Client, Patient or Guardian Signature Date

I authorize payment of medical benefits be made to the physician or supplier for services received.

_____ ___ / ___ / ___
Client, Patient or Guardian Signature Date

_____ ___ / ___ / ___
Client, Patient or Guardian Signature Date

The signature of a parent or legal guardian is required if the client is under 18 years of age or legally incompetent.

Signature on File

(Please initial each applicable line and sign at bottom of the page)

___ ___ I authorize use of this form on all my insurance submissions.

___ ___ I authorize release of information to all my insurance companies.

___ ___ I understand that I am responsible for my bill.

___ ___ I authorized Dr. Anthony J. Smith Ph.D., (Alase Center for Enrichment) to act as my agent in helping me to obtain payment from my insurance companies.

___ ___ I authorize direct payment to Dr. Anthony J. Smith Ph.D., (Alase Center for Enrichment).

___ ___ I permit a copy of this authorization to be used in place of the original.

_____ ___ / ___ / ___
Client, Parent or Guardian Signature Date

_____ ___ / ___ / ___
Client, Parent or Guardian Signature Date

The signature of a parent or legal guardian is required if the client is under 18 years of age or legal incompetent.

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CLIENT: **RECORD NUMBER:** **DATE OF BIRTH:**	**The client must always be given a copy of this form after signing.** Complete as needed. Use for disclosing information to other agencies or requesting information from other agencies. In the following cases, minors have the right to release information without parent's signature; these minors have the same rights as adults: 1. Emancipated minors 2. Minors receiving Substance Abuse treatment 3. Minors receiving treatment without parental consent.

RECIPROCOL RELEASE OF INFORMATION

I, [print name] _____, hereby authorize the release of information

☐ **TO** ☐ **FROM: ALASE CENTER FOR ENRICHMENT II**
(Please Check)

☐ **TO** ☐ **FROM:** _____
(Please Check) Person/Agency

FOR THE PURPOSE OF: ☐ Assessment, ☐ Treatment Planning, ☐ Referral, and/or ☐ Coordination of Services.

Please **INITIAL** below indicating which documentation regarding your treatment may be released and/or exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

DOCUMENT REQUESTED

_____Assessment/diagnoses	_____Service plan(s)	_____Physician's Orders/medication history
_____Treatment history	_____Medical history	_____Educational history
_____Social/developmental history	_____Discharge summary	_____Evaluation(s): _____

_____Other (specify) _____

_____Release of records is authorized even if such records contain information related to substance abuse.

_____Release of records is authorized even if such records contain information related to HIV/AIDS.

_____In addition to the initial disclosure of identified information I authorize periodic verbal exchange of information **ALASE** and the noted agencies.

I understand the federal privacy law regarding the protection of substance abuse information per the confidentiality and disclosure requirements of 42 CFR Part 2 and the requirements for protection of HIV/AIDS information under G.S. 130A-143; however, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure.

I understand what information will be released, the purpose of the release of the information, and that there are statutes and regulations protecting the confidentiality of the information. **ALASE's** NOTICE OF PRIVACY PRACTICES describes the circumstances where disclosure is permitted or required by state or federal laws.

I understand the terms of this release and voluntarily give my authorization. I understand that I may refuse to sign this authorization form and understand that **ALASE** will not condition my treatment, or any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this authorization.

I further understand that I may revoke my authorization by giving written notice to **ALASE.** Such revocation does not affect the validity of the consent for information disclosed/released prior to the revocation. If not revoked earlier, **this authorization expires automatically one year from the date** it is signed or upon _____whichever is earlier.
(date or event specified by client or dictated by the purpose of the authorization)

Signed _____ Date _____
(Specify if signature is that of client, parent(s), legal guardian, or personal representative)

Witnessed _____ Date _____
(Witness signature is required only if the form is sent out of state **or** if the above client signature has been signed by a mark)

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Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

I, undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization.

Patient Authorization

☐ I agree to release any applicable mental health/substance abuse information to my PCP

Primary Care Physician _____

Address _____

Telephone number _____ Fax number _____

☐ I agree to release my medication information to my PCP

☐ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.

☐ I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

_____

Patient Signature Date

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting Alase Center for Enrichment II.
- If you make a request to end this situation, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use of disclose information.

Patient Information

Patient Name _____ D.O.B. _____

Evaluation Date _____ Reason/Diagnosis _____

Summary/Findings/Recommendations _____

_____

_____

_____

Instructions: Please send a copy of this signed form to the PCP and keep the original in the treatment record.

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