***Wise Mind Psychological Services P.L.L.C.***
*3330 Park Ave. Suite 9, Wantagh, New York 11793*
*77 N. Centre Ave. Suite 310 Rockville Centre, NY 11570*
Phone: 516-740-1950

***Adult Registration Form***

*EVERYTHING MUST BE FILLED OUT COMPLETELY-PLEASE PRINT CLEARLY.*

_________________________________ ____________________ ______
Name (Last name, First name) Date of Birth Age

Address: ________________________________________________________________

City: _____________________State:______________________ Zip: _______________

Social Security #:_____________________________

Telephone Numbers: (H) ________________ (C) ________________ (Wk) ___________

Appointment with: _____________________________ Referred by: _______________

Emergency Contact:
Name: __________________________ Phone: __________________________
Relationship: _____________________

Primary Care Physician's:
Name: __________________________ Phone: __________________________

If currently prescribed medication, Psychiatrist's or Prescribing Physician's:
Name: __________________________ Phone: __________________________

If applicable, Case worker, CPS worker, Previous Therapist, Probation/Parole, or Legal aid's:
Name: _____________________Phone: _______________________Title: __________
Name:_____________________Phone: _______________________Title: __________
Name:_____________________Phone: _______________________Title: __________
Name:_____________________Phone: _______________________Title: __________

Reason for Services at this time:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Marital Status: _________________________ Children: _________________________
Highest Level of Education Completed:

______________________________________________

Occupation: _______________Employed ____ Yes ____ No, Since__________
Employer:_________________________________Address:_______________________

Describe any special circumstances such as medical conditions, illness, death, separation, relocations, or other stress or setback:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you used drugs in the past? No ____ Yes ____ If yes, how long ago? _____________
Are you currently taking drugs? No ____ Yes ____ If yes, since when? _______________
Have you used alcohol in the past? No ____ Yes ____ If yes, how frequently? ____________
Are you currently drinking alcohol? No ____ Yes ____ If yes, since when? ______________
Do you have a history of suicidal thoughts? No ____ Yes ____ If yes, how recent? ______________
Do you have a history of suicidal attempts? No____Yes____If yes, how recent?_______________
Are you currently having suicidal thoughts? No ____ Yes ____ If yes, since when? _______________
Do you have any allergies? No ____ Yes ____ If yes, please list:
________________________________________________________________________

Date of most recent medical exam: _______________________________________
Did you have legal problems in the past? No ____ Yes ____ If yes, how long ago _______________
Are you currently in any legal difficulty? No ____ Yes ____ If yes, briefly describe___________________

A- Psychological services received in the past or at present:

| Age at time | Length of Treatment | Reason for Treatment | Past | Present |
|---|---|---|---|---|

B- Psychiatric Medication taken in the past or at present :

| Medication & Dosage | When taken | Reason for medication | Past | Present |
|---|---|---|---|---|

C- Hospitalizations (or other Medical Services) for surgery, illness, or accident:

| Age at time | Length of stay | Reason for hospitalization | Location |
|---|---|---|---|

I certify this information is true and correct to the best of my knowledge. I understand that all information that I communicate will be held in strict confidence. I also understand that New York State also mandates certain limits to confidentiality. *These laws may obligate my mental health provider to report suspected abuse or neglect, domestic violence and those who pose a danger to themselves or others.*

Signature: ____________________________________ Date:______________

**Insurance Information**

Patient Name: ___________________________________ DOB: ______________________

Primary Insurance Co:________________________Address:_____________________________

City:__________________________State:________Zip:_______Phone:________________

Insurance ID #:___________________________Policy Holder:__________________________

Policy Holder's Date of Birth:______________Policy Holder's Address__________________

_________________________________State:______Zip:______Phone:________________

Secondary Insurance Co.______________________Address____________________________

City:_________________________State:________Zip:_______Phone:___________ ______

Insurance ID#____________________________Policy Holder: _________________________

Policy Holder's Date of Birth:______________Policy Holder's Address:__________________

_________________________________State:______Zip:______Phone:________________

**Please make sure you take care of paying your co-pay at the time of your appointment before leaving the office, if you have one. If we have to bill you there will be an extra $15.00 Administration Fee that you will be responsible for paying too.*

**If you must cancel an appointment please notify your therapist or the office 24 hours in advance. There is a $65.00 fee for a missed/no show appointment or a cancellation with less than a 24 hour notice.*

*Our schedules are booked in advance. If for any reason when you get home and check your schedule there is a conflict, please call right away so we can accommodate you. We will try our best to notify you of any schedule changes in advance as well.*

*~Thank you for your cooperation.*

Who is responsible for this bill? ___________________________________________

I certify this information is true and correct to the best of my knowledge. I understand the above statements and I will notify Rachel M. Bowley Psy.D. of any changes in my health insurance status. If I do not notify you of any changes and my insurance does not cover any services rendered, I will be ultimately responsible.

Signature: ____________________________________ Date:______________

## Patient Privacy Policy

In response to the misuse of Personal Health Information (PHI), the Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI is kept private. This rule was also established in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or health care operations.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your PHI in order to provide health care that is in your best interest.

We support your full access to your personal medical records. You should be aware that we may have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose PHI for purposes of treatment, payment and/or health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse to consent to the use or disclosure of your PHI. The refusal must be made in writing. Under the HIPPA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI. This refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.
You have received a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have received our privacy notice.

Print Name__________________________Signature_______________________Date__________

# Patient Bill of Rights and Responsibilities

## Patient Rights

***I have a right to efficient and effective care individualized to my needs.*** *My treatment provider will work with me to develop a treatment plan best suited to me. We will use this plan to help us deal with my problems as quickly and effectively as possible.*

***I have a right to be treated with dignity and respect.*** *I will be treated with respect at all times. I will report any misconduct by my treatment provider including social invitations, suggestive remarks, or unwanted touching Rachel M. Bowley Psy.D. and/or the appropriate state agency.*

*I may call Rachel M. Bowley Psy.D. at any time with questions, comments or complaints.*

***My treatment provider will make every effort to meet with me at our scheduled appointment time.*** *If my treatment provider is late, he or she will extend our session, if I am willing, or we will make other arrangements by mutual agreement.*

***I have a right to privacy and confidentiality.*** *All records and communications about me will be treated confidentially in compliance with applicable state and federal laws. These laws may obligate my mental health provider to report suspected abuse or neglect, domestic violence and those who pose a danger to themselves or others.*

## *Patient Responsibilities*

***Scheduled appointments are commitments****. I will make every effort to be on time for my appointment(s). If I am late for my appointment, I understand that time will be lost from my session. If I miss an appointment and do not notify my treatment provider at least 24 hours in advance, I understand I will be charged a missed appointment fee.*

***I am responsible to pay for services received.*** *I am aware my insurance plan typically requires me to pay a co- payment (a dollar amount) or co-insurance (a percentage of my treatment provider's fee) at the time services are provided. My insurance plan may also have a deductible (an initial dollar amount) that is my responsibility. Additionally, certain services may be limited and not covered at all by my insurance plan. I understand I am financially responsible for co-payments, co-insurance, deductibles and all services not covered by my insurance plan. My treatment provider, my managed care and my insurance plan's representative will help me determine what services my insurance plan covers.*

***My health is my responsibility.*** *I will contact my treatment provider for any serious situation that arises, even if after normal office hours. I will work with my provider to achieve my treatment goals and will advise my treatment provider of changes in my condition.*

*I have read this list of rights and responsibilities or had them read to me. I understand and agree to them.*

*Print Name______________________________Signature________________________Date ________________*