Patient Registration Form

***Demographics:***

Name: First M.I. Last: Sex: □ M □ F

Date of Birth (MM/DD/YYYY): Email:

Address:

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phones\*: Home: (\_\_\_\_\_\_)- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: (\_\_\_\_\_\_) -\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Status: □ Single □ Married □ Other: Employed: □ Y □ N Student: □ FT □ PT

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you choose our office? □ Physician □ Insurance □ Website □ Word of Mouth □ Family or Friend

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_\_\_) - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Insurance/Policy Holder Information:***

Relationship to client *(please circle one):* Self Spouse Parent/Guardian Other:

Subscriber Name: First M.I. Last: Sex: □ M □ F

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Using (Please circle one): Primary Insurance EAP Benefits

Policy/Subscriber ID: Insurance Co.: Group:

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Emergency Contact:***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phones: Home: (\_\_\_\_\_) - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: (\_\_\_\_\_\_) - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Assessment**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Presenting Problem (referral source, current symptoms, behaviors, and stressors): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Mental Health History (onset, symptoms, previous treatment – hospitalizations, providers, dates – in order): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychological History:**

1. Prenatal/Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Childhood/Adolescence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Family History (financial issues, relationship issues, placement history): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Social Relationship & Support (Significant others, friends, support system): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

|  |  |  |
| --- | --- | --- |
| \_\_\_ Head Injury/Stroke | \_\_\_ Thyroid Problems | \_\_\_ Chronic Pain |
| \_\_\_ Loss of Consciousness | \_\_\_ Cancer | \_\_\_ Enuresis/Encopresis |
| \_\_\_ Kidney Disease | \_\_\_ Diabetes | \_\_\_ Allergies |
| \_\_\_ Heart/Vascular Problems | \_\_\_ Sleep Disturbances | \_\_\_ Adverse Reaction to Meds |
| \_\_\_ Hypertension | \_\_\_ Appetite Changes | \_\_\_ Parasites/Scabies/Lice |
| \_\_\_ STD | \_\_\_ Respiratory Problems | \_\_\_ Seizures |
| \_\_\_ Liver Disease | \_\_\_ Weight Changes | \_\_\_ Pregnancy |
|  |  |  |

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Medications*** | ***Dosage*** | ***Date Started*** | ***OTC (Y/N)*** | ***Reported Side Effects*** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Name and Phone Number of Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Use History (Alcohol, Stimulants, sedatives, hallucinogens, nicotine):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type | Date of Last Use | Amount of Last Use | Frequency & Amount of Use | Length of Time Using | Age of 1st Use |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Treatment/Recovery History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risk Factors (Check ALL that apply):**

|  |  |
| --- | --- |
| \_\_\_ Homicidal/Assaultive | \_\_\_ Legal Issues |
| \_\_\_ Suicidal/Self-Harm | \_\_\_ Crime/Gang Involvement |
| \_\_\_ Access to Weapons | \_\_\_ Inappropriate/Risky Sexual Behavior |
| \_\_\_ Trauma | \_\_\_ Substance Use/Abuse |
| \_\_\_ Neglect/Abuse | \_\_\_ Cognitive Impairment |
| \_\_\_ Domestic Violence | \_\_\_ Risk of Homelessness |
| \_\_\_ Cultural Isolation | \_\_\_ Potential for Victimization |

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Status Exam (Circle ALL that Apply):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Appearance:** | Clean | Well-Groomed | Disheveled | Bizarre | Malodorous |  |  |
| **Motor** | Normal | Decreased | Agitated | Tremors | Tics | Repetitive | Impulsive |
| **Behavior** | Cooperative | Evasive | Uncooperative | Threatening | Agitated | Combative | Guarded |
| **Consciousness** | Alert | Lethargic | Stuporous | Current Situation | |  |  |
| **Orientation** | Person | Place | Time |  |  |  |  |
| **Speech** | Normal | Slurred | Loud | Pressured | Slow | Mute |  |
| **Affect** | Appropriate | Labile | Restricted | Blunted | Flat | Congruent | Incongruent |
| **Mood** | Normal | Depressed | Anxious | Euphoric | Irritable | Congruent | Incongruent |
| **Thought Process** | Coherent | Tangential | Circumstantial | Loose | Paranoid | Concrete |  |
| **Hallucinations** | Auditory | Visual | Olfactory | Gustatory | Tactile |  |  |
| **Intellect** | Average | Above average | Below average |  |  |  |  |
| **Memory** | Good | Poor recent | Poor remote | Confabulation |  |  |  |
| **Insight** | Good | Fair | Poor | Limited |  |  |  |
| **Judgment** | Good | Fair | Poor | Unrealistic | Unmotivated | Uncertain |  |

Diagnosis Summary:

Axis 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis 4: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis 5: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The name of the disorder according to DSM 5 classification followed by the numerical ICD-10 code and description.

Mental Health Conclusions/Narrative Summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  FINANCIAL POLICY FOR SERVICES RENDERED

## 

Note that payment of your bill is considered part of your treatment, and payment is due at the time service is provided. As a

courtesy to you we will help you process your insurance claims. Your insurance company and your plan benefits ultimately determine the amount paid by them. All charges you incur are your responsibility regardless of your insurance coverage; our relationship is with you, not with your insurance company. We ask that you any deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time we provide service to you. If your insurance has not made payment within 6 0 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

***Consent:***

*The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to CRA Counseling & Consulting Agency and the provider. I understand that I am financially responsible for any balance or unpaid claim. I also authorize CRA Counseling & Consulting or insurance company to release any information required to process my claims.*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Scheduled Appointments

If you need to cancel an appointment for any reason, please do so 24 hours before the appointment time. ***It is office policy to charge a $30 no show for missed appointments not canceled 24 hours prior***. Insurance does not cover missed appointment charges; they are the responsibility of the client or guardian. Our office does provide courtesy reminders of your scheduled appointment**. In the event these reminders are not made, it does not excuse a missed appointment.**

**CLIENTS WILL NOT BE ALLOWED TO RESCHEDULE IF THEY MISS MORE THAN 4 APPOINTMENTS WITHIN A 6 MONTH INTERVAL PERIOD OF TIME RESULTING TO BEING DISCHARGED FROM THE PRACTICE.**

**NEW CLIENTS WHO HAVE ONLY HAD AN INTAKE COMPLETED ARE TECHNICALLY NOT IN THE PRACTICE AND WILL BE DISCHARGED IMMEDIATELY IF THEY FAIL TO KEEP SUBSEQEUNT APPOINTMENT.**

**EXCEPTION TO POLICY: MEDICAL ISSURANCE CLIENTS ARE NEVER CHARGED A MISSED FEE BUT WILL NOT BE ALLOWED TO RESCHEDULE IF 3 APPOINTMENTS ARE MISSED WITHIN A 6 MONTHS PERIOD**

## Fees and Payment

Payment will be collected at the time service is rendered. In the case that a client has a third-party insurance payer, either the client or CRA Counseling & Consulting Agency will file with the insurance. If for any reason your insurance company does not cover services, the client or guardian will be responsible for all charges. You will be notified of any insurance difficulties. Statements are provided upon request.

**Medical Assistant Fees:**

90791 (Diagnostic Intake Interview – 60 Mins) – $112.50

90834 (45 Min Individual Counseling Session) – S70.05

## Failure to Pay

The client agrees that failure to pay within **ten** business days of the service date may, at the option of CRA Counseling & Consulting Agency, be construed as a discharge of services by the client.

***Your signature below indicates understanding of the fees and policies as delineated above.***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Phone and Email Policies

***Therapist and Counselor Contact Outside of Sessions***

If there is an emergency, please call emergency services or 911. If you are calling to make or change your appointment or to address billing issues, please call the office at (410) 744-4204 or email us at candicerdickens@gmail.com. If you would like to talk with your therapist, and cannot wait until the next appointment, please be respectful of their time.

**45 MINUTE PHONE SESSIONS ARE NOT COVERED BY INSURANCE COMPANIES ONLY IN CASE OF AN EXTREME CRISIS**

***Telephone, Internet, and email communication carry an inherent risk to privacy. By signing below, I indicate recognition of these risks. I have reviewed and understand these options and I have received a copy of the Phone and Tele therapy Policies.***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Notice of Privacy Practices (HIPAA), Client Bill of Rights and Confidentiality of Client Records

### **Client Bill of Rights**

Each Client has the right to:

1. Be treated with consideration, respect, and full recognition of the client’s human dignity and individuality; 2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;

1. Not be physically or mentally abused by the program staff;
2. Be free from discrimination;
3. Be free from restraints;
4. Privacy and confidentiality; and
5. Refuse participation in any experimental research unless the research complies with 45 CFR Part 46. 45 CFR Part 46 is the Code of Federal Regulations Protection of Human Subjects.

### **Confidentiality of Patient Records**

The Federal Law and Regulations protect the confidentiality of patient records maintained by this program. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug user unless:

1. The patient consents in writing;
2. The disclosure is allowed by court order;
3. The disclosure is made to medical personnel in an emergency or to qualified personnel for research, audit, or program evaluation.

Insurance companies have the right to ask about your counseling to determine if treatment is necessary and appropriate. Your therapist will be required to provide a diagnosis and may need to submit a report outlining what you are working on and how long it is likely to take to achieve your goals. If there is anything you wish to discuss in therapy that you do not want shared with anyone, including your insurance company, please discuss this with your therapist. Insurance companies also requires that we provide a diagnosis, using the nationally approved DSM 5 or ICD-10 criteria. Your diagnosis, like all your medical information, is protected by privacy and confidentiality rules and practices. However, some clients fear being labeled or “stigmatized” by their diagnosis, or fear that it could limit their career options or insurance rates. If you have any such fears, please speak about them to your therapist.

Violation of Federal Law and regulations by a program is a crime. Suspected violations may be reported to

appropriate authorities in accordance with federal guidelines. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being

reported under state law to appropriate state and local authorities.

### **Acknowledgment and Consent Regarding Notice of Privacy Practices**

Our Notice of Privacy Practices is available upon request. The Notice of Privacy Practices of CRA Counseling & Consulting Agency (CRA) provides information about how CRA may use and disclose my protected health information (PHI). The Notice of Privacy Practices states that CRA reserves the right to change its terms. Should this happen, understand that CRA will make the changed notice available in its office. You have the right to revoke this consent, in writing, except where CRA has already made disclosures in reliance on your prior consent. Understand that you have the right to request restrictions on how your PHI may be used or disclosed for treatment, payment and health care operations. CRA is not required to agree to your restrictions, but if it does, it is bound by its agreement with you. By signing below, you consent to the use and disclosure of your PHI for treatment, payment and health care operations as described in the Notice of Privacy Practices. You specifically consent to CRA communicating with you using the contact information you provide, as further described in the Notice of Privacy Practices.

### **Discharge**

Clients who choose to terminate services will be discharged immediately. Clients who have not attended sessions for 30 days or more and who do not have an appointment scheduled will be discharged at the discretion of the doctor or therapist with no prior notice. Discharged clients are no longer under the care of CRA Counseling & Consulting Agency, Integrative Counseling, a therapist, or a doctor. Discharged clients may be re-admitted at the discretion of the practice upon request.

***I have reviewed and understand these rights and I have received a copy.***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Consent of Treatment

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_agree to allow CRA Counseling and Consulting Agency to provide me with mental health services at 5602 Baltimore National Pike, Suite 304, Catonsville, MD 21228.

I am aware that the expectation of my treatment included completing homework skill-based assignments, watching video tapes, and completing assigned readings.

I am aware that I have the right to terminate this agreement of consent at any time and am aware of the discharge policy of CRA Counseling & Consulting Agency.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risk Section**

There are potential risk to psychotherapy. People may initially feel worse as the therapy progresses. In rare cases, psychotherapy may even trigger some people to have thoughts about wanting to hurt themselves or end their lives. When this happens, your therapist will be able to help you understand and cope with these feelings safely and can direct therapy to be more supportive until you are feeling stronger. It is always important to tell your therapist if you are having frightening or dangerous thoughts or feelings, or if you are considering harming yourself or someone else.

Some clients develop strong feelings about their therapist. This is especially true in longer therapies. Such feelings are normal, even if sometimes uncomfortable or confusing. Any feelings are possible, and the rule for them all is to talk them over with the therapist. They are experienced with this and will help you understand how this is part of your progress.

Therapy can complicate your life. Therapy is often about making changes or about looking at yourself differently. Therapy can change how you live, and it can change how you feel about your relationships. Your therapist will help you to anticipate these changes and will let you decide what changes are best for you and when.

Some research suggests that when one spouse or partner meets alone with a therapist to discuss problems involving the other partner, there is a chance that this could increase tension for the couple. For this reason, many marital or relationship problems are best addressed with both individuals coming to therapy together.

While your therapist could offer suggestions and advice when asked, research shows that a therapist’s advice about life problems is often no more helpful than anyone else’s. helping you find your own solutions to your life’s problems is a far more effective approach.

Finally, not all therapy is effective. If you have been in therapy for several week or months, and it does not feel like you are making progress, you should speak to your therapist. It may be that you would do better with a different approach to therapy, or even with a different therapist. As therapist, we know that we cannot be everything to everybody, and we are comfortable helping you make a change if needed.

\_\_\_\_\_ OPTIONAL \_\_\_\_\_

## Release of Information

I, hereby authorize CRA Counseling & Consulting Agency

to exchange information with: .

Name of Program, Agency, or Individual

Phone Fax

The following information may be exchanged:

Full client record

Progress and attendance reports

Admission and discharge diagnosis and recommendations

Reason for termination of treatment and discharge summary

\_\_\_\_\_\_ Other

The above information will be exchanged for the following reason(s):

To coordinate treatment

As a condition of probation, parole, or adjudication

As required by my employer or EAP

To assist my attorney

\_\_\_\_\_ Other

This consent will expire one year from the date of signature unless otherwise noted

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that the information has already been disclosed in reliance with this consent.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidentiality Notice**

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