Shoreview Mental Health Center LLC
hope · · · wellness · · · peace
P: (651) 348-7240 | F: (651) 348-7265 | www.shoreviewmentalhealth.com
Rice Creek Professional Building | 5985 Rice Creek Parkway | Suite 201 | Shoreview, MN 55126

REGISTRATION INFORMATION

Date: _____

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	BIRTHDATE	GENDER

HOME ADDRESS	CITY	STATE	ZIP	SPOUSE'S NAME

SOCIAL SECURITY #	MARITAL STATUS	MAIN PHONE #	SECONDARY #
EMAIL	☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED	☐H ☐W ☐C	☐H ☐W ☐C

EMPLOYMENT INFORMATION

CLIENT'S EMPLOYER/SCHOOL NAME	JOB TITLE OR STUDENT	EMPLOYMENT OR STUDENT STATUS
		☐FULL-TIME ☐NOT EMPLOYED ☐PART-TIME ☐SELF EMPLOYED ☐RETIRED ☐ACTIVE MILITARY

CLIENT'SEMPLOYER/SCHOOL ADDRESS	CITY	STATE	ZIP

EMERGENCY INFORMATION

NAME	RELATIONSHIP

ADDRESS	CITY	STATE	ZIP	PHONE #

RESPONSIBLE PARTY INFORMATION

RELATIONSHIP TO CLIENT: ☐ SELF (OK TO SKIP TO NEXT SECTION) ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER _____

RESPONSIBLE PARTY NAME: LAST	FIRST	M.I.	RESPONSIBLE PARTY BIRTHDATE

RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP	RESPONSIBLE PARTY HOME #

RESPONSIBLE PARTY EMPLOYER	OCCUPATION (JOB TITLE)	RESPONSIBLE PARTY WORK #

RESPONSIBLE PARTY EMPLOYER ADDRESS	CITY	STATE	ZIP	RESPONSIBLE PARTY SOCIAL SEC #

INSURANCE INFORMATION

PRIMARY INSURANCE	POLICY HOLDER	DATE OF BIRTH

IDENTIFICATION NUMBER	GROUP NUMBER

CLAIMS ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

SECONDARY INSURANCE	POLICY HOLDER	DATE OF BIRTH

IDENTIFICATION NUMBER	GROUP NUMBER

CLAIMS ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

COORDINATION OF CARE

Please Provide Primary Care Provider Information: ☐N/A

☐SMHC therapist may coordinate care with PCP

☐SMHC therapist may *not* coordinate care with PCP

PCP Name: _____

PCP Phone: _____ Fax: _____

PCP Address: _____

Please Provide Psychiatrist Information: ☐N/A

☐SMHC therapist may coordinate care with Psychiatrist

☐SMHC therapist may *not* coordinate care with Psychiatrist

Psychiatrist Name: _____

Psychiatrist Phone: _____ Fax: _____

Psychiatrist Address: _____

HOW DID YOU HEAR ABOUT US? _____

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IMPORTANT SIGNATURES

Please print the client's full name: _____

FINANCIAL POLICY/MISSED APPOINTMENT POLICY

My signature below indicates that I have been provided with a copy of SMHC's Financial Policy.
I acknowledge that I am responsible for any payments not billable and/or covered by insurance.
I have made payment arrangements with a credit/debit card on file and/or other payment options made available to me for services rendered by SMHC. In compliance with health insurance contracts, SMHC cannot waive co-pays or co-insurance amounts.

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been provided with a copy of the HIPAA Omnibus Notice of Privacy Practices. I understand all medical records are kept confidential unless a separate release of information form is signed by me authorizing the release of these medical records.

I hereby authorize SMHC to release my medical records to my insurance company for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payer.

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment to SMHC of any medical benefits otherwise payable to me for services provided by a Mental Health Professional affiliated with SMHC.

CONTACT INFORMATION

SMHC considers your e-mail and other contact information to be confidential.
We will not disclose or sell any of your contact information to outside parties or entities.

APPOINTMENT REMINDERS & FILLING CANCELLED APPOINTMENTS

☐ I hereby authorize SMHC to send appointment reminders via email and/or text.
☐ I hereby give consent to be notified via email and/or text of appointment openings with my therapist.
☐ I elect to opt out of all email and/or text communication with SMHC.

EMAIL ADDRESS: _____

CELL NUMBER: _____

My signature confirms that I have received these forms and have been given the opportunity to ask questions about them.

X_____ _____

Signature of Client or Personal Representative **Date**

If signed by a personal representative, relationship to client: _____

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FINANCIAL POLICY

1. Client accepts primary responsibility for verifying insurance coverage for services provided by Shoreview Mental Health Center (SMHC) even if SMHC is also in contact with client's insurance company. Client further understands that verification of coverage by phone is not necessarily a reliable or accurate determination of benefits.
2. Client understands that he/she is responsible for all co-pays, deductibles and payments as outlined in client's insurance policy. Client also understands that not all services are covered benefits in all contracts, and in such cases, the client is solely responsible for payment, according to the guidelines of the respective insurance contract.
3. Client authorizes SMHC to file insurance claims on client's behalf, along with the release of records, including psychotherapy notes, or other medical billing data necessary to process claims to client's insurance carrier.
4. Client authorizes insurance benefits to be assigned to Shoreview Mental Health Center, LLC for healthcare services provided to client by providers at Shoreview Mental Health Center, LLC.
5. Client accepts full responsibility for client's account balance, regardless of client's insurance status or coverage problems arising out of separation or divorce status. Client agrees to notify SMHC of any changes regarding the status of client's insurance.
6. Client accepts sole responsibility for pursuing legal action for benefits or payment against an insurance company.
7. Client understands that testing has a separate fee and client is responsible for payment if insurance does not cover.
8. Client authorizes SMHC to release client's account to a collection agency in an attempt to collect an unpaid debt.
9. Client understands that if there is a returned check on client's account, Client is responsible for a service charge; and if the check is not taken care of immediately, it will be turned over to a collection agency.
10. Client understands any charges incurred for phone consultations, letters, reports, or disability forms completed on client's behalf will be client's responsibility.
11. Client understands that a late cancellation fee may be assessed if a session is missed or if client does not notify SMHC of a cancelled appointment 24 hours prior to the scheduled appointment time.

Client Name: _____

Client/Guardian Signature: _____ Date: _____

Relationship to Client: _____

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INFORMED CONSENT

General Information
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what all parties can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with your therapist.

The Therapeutic Process
You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. We can promise to support you and do our very best to understand you, help you understand yourself, and look for ways to help you better manage whatever issues you are experiencing.

Confidentiality
The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another identifiable person.

3. If the therapist has a reasonable suspicion that a client or other named victims is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person or vulnerable adult who may be subjected to these abuses.

5. If a court of law issues a legitimate court order for information.

6. Information provided to insurance carriers that is necessary for filing of insurance claims, which may include service code, diagnosis, psychotherapy notes, or other medical billing data necessary to process claims to client's insurance carrier.

7. Information provided to a collection agency to facilitate the collection of past due accounts, which may include but not limited to service code and amount due.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

_____ _____
Signature of Patient/Client or Personal Representative **Date**

_____
Printed Client Name

_____
If signed by a Personal Representative please state relationship to Client