MADISON COUNSELING ASSOCIATES

Patient Registration Form

Full Name of Patient: _____ **Today's Date:** _____ **Therapist:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Daytime Phone: _____**Email:** _____
Patient DOB: _____ **Age:** _____ **Sex:** _____ **Marital Status:** _____
Patient Education Level: _____ **Patient Occupation:** _____
Employer: _____
Spouse Name: _____ **Spouse DOB:** _____ **Phone:** _____

IF YOU HAVE OBJECTIONS TO OUR OFFICE MAKING CONTACT WITH YOU AT HOME OR WORK REGARDING APPOINTMENTS, PLEASE NOTE HERE.

Please tell us who referred you to us: _____ Phone: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:
Father's Full Name: _____
Father's Place of Employment: _____ **Work #:** _____
Mother's Full Name: _____
Mother's Place of Employment: _____ **Work #:** _____
If Patient is a student, his/her grade: _____ **School:** _____

Who is responsible for payment for services? _____
Address, if different than that of patient: _____

INSURANCE INFORMATION:
Primary Insurance Company: _____
Address: _____
Phone #: _____ **Policy #:** _____ **Group #:** _____
Insured's Name: _____ **Insured's Employer:** _____
Insured's DOB: _____ **Insured's SSN:** _____

IN CASE OF EMERGENCY, PLEASE CONTACT:
Name: _____ **Relationship**: _____
Phone #: _____ **Secondary Phone** #: _____

SYMPTOM CHECKLIST

Patient Name: _____ **Date:** _____

Please check as many of the following items that apply to you. Do you have trouble with?

SLEEP PROBLEMS
- □ Difficulty falling asleep
- □ Early morning waking
- □ Waking during the night
- □ Feeling tired when waking
- □ Increase in dreams
- □ Unpleasant Dreams
- □ Excessive sleep

CHANGES IN
- □ Weight __ lbs. lost/gained
- □ Health
- □ Sexual interest
- □ Sexual performance
- □ Appetite
- □ Energy level

FEELINGS OF
- □ Anxiety
- □ Tiredness
- □ Boredom
- □ Lack of interest
- □ Sadness
- □ Depression
- □ Despair
- □ Worthlessness
- □ Helplessness
- □ Emptiness
- □ Rage
- □ Tension
- □ Loneliness
- □ Guilt
- □ Hopelessness

THOUGHTS OF
- □ Harming yourself
- □ Harming others

DO YOU HAVE ALLERGIES
- □ Yes_____
- □ No

RECENT HISTORY OF
- □ Nausea/vomiting
- □ Diarrhea
- □ Fever/chills
- □ Sweating
- □ Chest pain
- □ Dizziness
- □ Headaches
- □ Trembling
- □ Lower back pain
- □ Dry mouth
- □ Shortness of breath
- □ Palpitations
- □ Rapid breathing
- □ Head injury
- □ Loss of consciousness
- □ Loss of memory
- □ Confusion
- □ Seizure
- □ Bleeding
- □ Swollen Joints
- □ Numbness, tingling
- □ Paralysis
- □ Flashbacks
- □ Blackouts

DIFFICULTY WITH
- □ Short attention span
- □ Carelessness or sloppy work
- □ Listening when spoken to
- □ Following instructions
- □ Organizing tasks or activities
- □ Avoiding home/paperwork
- □ Losing things
- □ Forgetfulness
- □ Fidgeting/squirming in seat
- □ Sitting still
- □ Restlessness/hyperactivity
- □ Playing quietly
- □ Talking excessively
- □ Speaking out of turn
- □ Waiting for others
- □ Interrupting or intruding on others

CONFLICT WITH
- □ Spouse
- □ Family member
- □ Other loved one

PROBLEMS WITH
- □ Arguing a lot
- □ Lying
- □ Stealing
- □ Losing temper
- □ Avoiding people
- □ Spending/finances
- □ Sexual behavior
- □ Gambling
- □ Eating
- □ Fighting
- □ Increased drinking
- □ Substance Abuse
- □ Destroying things

FEAR OF
- □ Loss of control
- □ Death
- □ Being alone
- □ Places/situations
- □ Objects or animals
- □ Cancer
- □ AIDS
- □ Being possessed
- □ Being insane

EXPERIENCE OF
- □ Vivid dreams
- □ Nightmares
- □ Hearing voices
- □ Seeing visions
- □ Being out of body

PAYMENT POLICY

We will file your primary insurance and secondary insurance for you as a courtesy.

- **THE PATIENT/RESPONSIBLE PARTY IS ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES**
- Your insurance is a contract between you and your insurance company. We are not a party to that contract. In the event your insurance company does not pay within 60 days of the date of service, the account will be forwarded to you for payment.
- Changes in insurance information should be communicated with our office as soon as possible.
- If a service is or may be "non-covered" we will notify you in advance and ask you to sign an "Advance Beneficiary Notice."

Payment for all copays, deductibles and non-covered services are due at the time of service. We accept cash, check and credit cards. There will be a $30 service fee for each returned check.

CANCELLATION POLICY

We require 24-hour notice by phone or email for cancellation. As a courtesy we will make a reminder call or text the business day before your appointment (varies by clinician). Failure to cancel without 24-hour notice will result in a late cancel or no-show fee.

_____ (Initial) For **Late Cancellations** you will be charged up to $75.

_____ (initial) For **No-Shows** you will be charged up to $75.

Your session time is reserved for you and/or your family. A missed session is not reimbursed by insurance, and you will be responsible for covering the cost of your clinician's time. After multiple late cancellations or no-shows, you may be charged for the full amount of the session and/or **discharged by your therapist.**

NON-COVERED SERVICE POLICY

_____ (Initial) The individual LLCs contracted with MCA specializes in providing assessment and therapy for clients. We do not provide court testimony, court ordered evaluations or custody evaluations. In legal proceedings, your therapist may be compelled by a judge to reveal information about you that may affect you negatively or undermine the therapeutic relationship. Because that relationship is built on trust, with the foundation of that trust being confidentiality, we believe involvement in legal proceedings could be damaging to the therapeutic relationship. If your therapist is asked to testify or is subpoenaed by an attorney to appear in court, you agree to pay a retainer of up to $2000 two weeks prior to any court appearance, in addition to fees up to $300 **per hour** to include travel to and from legal proceedings, copies, records review, preparation of paperwork, consultation with attorneys, time spent in court waiting to testify and any legal fees incurred by your therapist as part of involvement in legal action.

_____ (Initial) Your clinician may be asked/required to perform additional services (professional communications, forms, reports, records requests, conferences etc.) on your behalf. You understand that such services will not be covered by insurance and will be the responsibility of the patient/responsible party. Services charges will range from $30-$160 depending on the level of complexity and time involved.

_____ (Initial) It is understood that, regardless of amounts reimbursed by your insurance company, you as the patient/responsible party will be responsible for full amounts charged. If your account is turned over to an attorney or collection agency for nonpayment, you will also be responsible for additional attorney or collection fees. If you are covered by managed care, you *may* be exempt from payment of charges not fully covered by your insurance.

LIMITATIONS ON CONFIDENTIAL NATURE OF COMMUNICATIONS

Communications between a licensed psychologist, psychiatrist or licensed professional counselor and patient are confidential and will not be released with the express written authorization of the patient. However, certain communications may be made, or certain situations may occur for which confidentiality is limited. These include:

- Situations in which a provider believes the patient is a threat to self or others.
- Situations in which records are ordered to be released by a judge of the courts, or
- When the communications involve the transmission of contagious or transmittable disease, or
- When the communications involve information regarding child abuse or elder abuse, or
- When the patient's account is turned over to a collection agency or attorney for non-payment

I hereby acknowledge that I have read, understand, and agree to the above Payment, Cancellation, Non-Covered Services Policies and Limitations of Confidentiality

Patient or responsible party: _____ **Date**: _____

Signature of MCA staff: _____ **Date**: _____

CONSENT

TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

This form is an agreement between the patient (print name) _____ Madison Counseling Associates LLC, and the specific clinician you are seeing for mental health services (their LLC). When we use the word "you," it can mean you, your child, a relative or other person. When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information internally to determine what treatment is best for you and provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment, or for other business of government functions. By signing this form, you are agreeing to let us use your information internally and to send it to others with your written authorization. The Notice of Privacy Practices pamphlet explains in more detail your rights and how we can use and share your information.

If you do not sign this consent form agreeing to what is in our Notices of Privacy Practices, **we cannot treat you.**

In the future, we may change how we use and share your information and as such may change our Notice of Privacy Practices form. Copies will be available at that time.

If you are concerned about some of your information, you have the right to ask us to not use or share that information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations.

After you have singed this consent, you have the right to revoke it (by providing your clinician a letter telling us you no longer consent) and we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

_____ **Receipt of copy of Notice of Privacy Practices is hereby acknowledged by client/parent/personal representative.**

Signature of patient/representative: _____ **Date:** _____

Printed name: _____ **Relationship to client:** _____

Signature of MCA staff: _____ **Date:** _____

Clinician Name: _____

CONSENT FOR BEHAVIORAL HEALTH TREATMENT

I hereby consent to the behavioral health treatment of _____ (**patient name**), by Madison Counseling Associates and LLCs contracted with MCA. My signature confirms my understanding that this treatment may include assessment, counseling, psychotherapy, and other forms of behavioral health intervention conducted in accordance with commonly accepted practices and standards in the field of mental health.

The outcome of treatment may depend on many variables beyond the control of the treating professional. Therefore, I understand that neither MCA nor my treating clinician (their LLC), can guarantee any specific outcome that will result from my treatment, nor that of any minor family member. I also understand that any payment for these services, whether made by me or by a third party, is payment made for the professional's time, experience, and effort, and not for any specific outcome.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Signature of MCA staff: _____ **Date:** _____

Clinician Name: _____

Appointment Reminders

We can send you an appointment reminder by **text message, phone call, or email (varies by clinician)**. The appointment reminder will include only the date and time of your appointment. Please be aware that a "Call Reminder" is a courtesy from *Madison Counseling Associates.*

- Telephone calls may be used for appointment information and other clinical matters.
  _____ (initial) I consent to being contacted by telephone.
  Phone number: _____

- If a voicemail is left it will state that you have been called by *Madison Counseling Associates, LLC* no clinical information will be left.
  _____ (initial) I consent to voicemails left at this number _____

- **Email** is the primary method used for appointment reminders with Madison Counseling Associates.
  _____ I consent to being contacted via email for appointment reminders.
  Email: _____
  _____ I do **NOT** consent to being contacted via email for appointment reminders, and I understand that I will not receive appointment reminders by email. I will be held responsible for keeping up my own appointment.

- **Text messages** are not generally used but, may be used only for appointment reminders should email not be available.
  _____ I consent to being contacted via text message for appointment reminders.
  Phone Number:_____
  _____ I do **NOT** consent to being contacted via text message for appointment reminders, and I understand that I will not receive appointment reminders by text message. I will be held responsible for keeping up my appointment.

Signature of Client/Responsible Party: _____ Date: _____

Signature of MCA Staff: _____ Date: _____

CONSENT OF COMMUNICATION

Communication with Client

Email: *Madison Counseling Associates*, LLC and contracted LLCs with MCA cannot guarantee the security and confidentiality of an email transmission. Emails to your therapist that contain Protected Health Information **(PHI)** are highly discouraged as the security and confidentiality of email cannot be guaranteed. If your email is a family address, other family members may see your messages. Please be aware that you email at your own risk. Because of the many internet and email factors beyond our control, we cannot be responsible for misaddressed, misdelivered, or interrupted emails. Your clinician is not liable for breaches of confidentiality caused by yourself or a third party. Your clinician will attempt to read and respond promptly to emails but cannot guarantee that any email will be read and responded to within any particular time period. ***Email should never be used for emergency or crisis situations.***

Social Media: Madison Counseling Associates, LLC and therapist do not communicate via social media.

Telephone: Communication outside of scheduled sessions should be accomplished by calling the office at 256-542-3288 and leaving a message if necessary. Every attempt will be made to respond to messages the same business day or within 72 hours at the latest. As stated above, most communication should take place during scheduled sessions; however, the office may need to contact you regarding scheduling, billing, or to provide requested information. ***Do not leave a message in an emergency or crisis situation as messages are not checked outside of scheduled workdays and business hours.***

Mail via USPS or other authorized carrier may be required should other methods of communicating with you be unsuccessful or should you request a document that can be transmitted only via mail.

Emergency Services*: Madison Counseling Associates does not provide 24-hour, on-call emergency services. In case of an emergency, you may seek help through these additional resources:*

- *911*
- *Crisis Services of North Alabama HELPline at 256-716-1000*
- *National Suicide Prevention Lifeline at 1-800-273-TALK*

Signature of Client/Responsible Party: _____ Date: _____

Signature of MCA staff: _____ Date: _____

Automatic Payment Processing

For your convenience, we will use this authorization to charge your credit card for any charges incurred as a result of services rendered at Madison Counseling Associates LLC. Your information will be kept confidential and only authorized staff will have access to the information. ***Please note there will be an additional $30 charge for an insufficient fund's transaction.***

By signing below, I authorize my clinicians LLC to keep my credit card information on file and to charge my credit card for services rendered at MCA for which I am responsible, without my physical presence at the time of charge.

- MCA staff and my clinician may utilize my payment methods on file for any balances, including but not limited to: Late cancellations (defined as within 24 hours of scheduled appointment), missed appointments, co-payments, co-insurance, or non-covered services and/or denial of services.
- If the method of payment expires or is denied for any reason, I agree to provide the MCA staff and/ or my clinician with a new and valid card for payment.
- If I wish to change the payment type in the future, I understand it is my responsibility to notify MCA staff and clinician of the desired change. I authorize the use of a payment method for the complete duration of my or my child's time in treatment with my clinician or until my account balance is fully paid for services rendered after termination of treatment.

Client Name: _____ **Clinician Name:** _____

Responsible Party: _____

Name as it appears on card, if different from above: _____

Cardholder's Signature: _____ **Date:** _____

Signature of MCA staff: _____ **Date:** _____

CREDIT CARD ON FILE
AUTOMATIC PAYMENT PROCESSING AUTHORIZATION

Credit Card Information

Notice: for your protection, this page of your intake packet will be shredded immediately after the information has been entered into our system.

Credit Card Number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: _____ Security Code: _____

Cardholders Billing Address: _____
Street address city state zip

CHECKING YOUR MENTAL HEALTH BENEFIT

CALLING YOUR INSURANCE COMPANY FOR BENEFITS

The following is a form concerning your outpatient mental health benefits. Since mental health benefits are sometimes different from medical benefits, we advise you to contact your insurance company.

While we do make every effort to verify benefit information prior to your initial appointment, not all information provided by insurance companies is accurate. By contacting your insurance company, you will have a better understanding of your benefits and should know what percentage you will be responsible for at each visit with your clinician. All insurance companies and policies are different, so please make no assumptions as to what is covered or not covered. ***This form is provided for your information, so you will know what questions to ask concerning your mental health coverage.***

On the back of your health insurance card there should be a toll fee number for you to call for your mental health/behavioral health benefits. If you do not have a card, you should have a benefits manual with the number in it. The following are questions you should ask the representative when calling. If your mental health benefits are covered under a managed care, ask your representative the name of the managed care company and the phone number for future inquiries.

Questions to ask your insurance company.

- Is psychotherapy (90791, 90834 or 90837) by a Licensed Marriage and Family Therapist (PhD), Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) covered under my plan?
- Is my clinician in network? If no, do I have out of network benefits?
- Does my policy require a Primary Care Provider (PCP) referral?
- What is my in/out of network deductible for mental health? _____ Is this a per calendar year deductible?
- Are there a limited number of visits per calendar year? If yes, how many? _____
- Do I need any pre-authorization for treatment? If yes, how many sessions are authorized and is a treatment plan required?
- What is my percentage of coverage?
- What is my co-pay/co-insurance?
- What is my maximum dollar amount per year?