New Patient Registration Form – IRIS HEIEREN, MA, LAMFT

AHeARTT

Date ____/____/____

Section I:	Patient Information

Name:		Age:
Address:		DOB:
City, State, Zip:		Sex: M ____ F ____
e-mail:		
Telephone: ( )		Marital Status:
Work Phone: ( )		Date of Wedding:
Cellular Ph. / Pager: ( )		
		Previous Marriage/Relationship:
Employment Status:		Yes ____ No ____
Occupation:		Length of Commitment:
Employer:		Reason for ending relationship:
Spouse / Significant Other Information:		
Name:		Age:
Address:		DOB:
Occupation:		Previous Marriage/Relationship:
Employer:		Yes ____ No ____ # of yrs _____

How did you hear about AHeARTT?

Section II:	Communication

Can therapist/office leave a message:	❑	yes	❑	no	Phone:
	❑	yes	❑	no	E-mail:
	❑	yes	❑	no	Other:
Communication preference:	❑	E-mail	❑		Phone: Home / Cell (circle one)

Do you wish to receive occasional **e-newsletters** including tips and ideas for improved well-being? (You have the option to automatically add or remove yourself from the list and your information is always private.)

❑ Yes ❑ No

Section III: Family Information

Who are the members in your family?	Age	Relationship	Notable health condition or concerns

Section IV: Reason for Visit/Goals for Assistance

Please describe the reason for your visit: _____

_____

_____

What is your primary concern or worry related to the current issue? _____

_____

_____

List five words that describe your thoughts and feelings related to your primary concern? _____

_____

_____

_____

_____

What are goals you hope to achieve from our visits?: _____

_____

_____

How have the following symptoms bothered you **recently**?

❑ - Significant/Major Problem ❍ - Slight/Moderate Problem

❑ ❍ Depressed, sad, or crying	❑ ❍ Inability to concentrate	❑ ❍ Anger or temper problems
❑ ❍ Suicidal thoughts, plans, or attempts	❑ ❍ Anxious, nervous, or panicky feelings	❑ ❍ Repetitive thoughts, behaviors
❑ ❍ Guilty feelings	❑ ❍ Insecurity or inferiority	❑ ❍ Memory problems
❑ ❍ Loss of interest or energy	❑ ❍ Change in spending habits	❑ ❍ Sexual worries / problems
❑ ❍ Physical problems, pain, or illness	❑ ❍ Periods of euphoria, boundless energy or unstoppable activity	❑ ❍ Confused or disorganized thoughts

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AHeARTT

Billing & Payment Policy

Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all services AHeARTT provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

Copayments: Copayments for clinic visits are due at the time of service.

Fees/Self-Pay: Initial intake and diagnostic sessions are $188; individual rates are $120/45 minute hour or $146/60 minute hour payable by insurance, cash, check or credit card. Fee's not covered by insurance are the responsibility of the client. Self-pay patients are expected to make payment in full at the time of service.

Missed Appointments & Late Cancels: If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. After three "NO SHOW" and or excessive late or last minute cancelled appointments, you will be discharged from our clinic and we will no longer see you as a patient.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour (BUSINESS DAY) notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Responsible Party for Billing

Name:		Relationship to Patient:	
Address: (if same as patient information write same)			
City:	State:	Zip:	Phone:
Employer:	Work Phone:		Cell Phone:
SSN#			

Insurance Information

Primary Insurance:		Policy Holder:	Date of Birth:
Identification Number:		Group Number:	
Claims Address:			
City:	State:	Zip:	Phone:
Secondary Insurance:		Policy Holder:	Date of Birth:
Identification Number:		Group Number:	
Claims Address:			
City:	State:	Zip:	Phone:

I understand and acknowledge the Billing & Payment Policy of AHeARTT / Alliance for Healing

Patient Name (printed) _____

Patient Signature_____ Date_____

Relationship to Patient_____
(if patient is unable to sign or under the age of 18)

Financial Policy

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms.

Appointments-

1. **Copayments.** Copayments for clinic visits are due at the time of service.

2. **Fees.** Initial intake and diagnostic sessions are $188; individual rates are $120/45 minute hour or $146/60 minute hour payable by insurance, cash, check or credit card. Fee's not covered by insurance are the responsibility of the client. Pre-payment for sessions at the time when the session is scheduled and/or when you present to our office may be required. Your prepayment is based on an estimate of your expected financial responsibility. You are responsible for any unpaid balance after your insurance (if applicable) has been billed.

3. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by AHeARTT you are considered a self-pay client. Payment for these services need to paid in full at the time of service.

4. **Missed Appointments and Late Arrivals.** A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice (business days) unless it is due to illness or an emergency. For Monday appointments, they need to be cancelled on Friday. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment. Please call or text your therapist to let them know you are cancelling your appointment.

Insurance Payments-

5. **Insurance/Coverage Changes.** It is your responsibility to inform us of any changes to your billing or insurance information. There is a time limit within which AHeARTT must submit a claim on your behalf to your insurer. If AHeARTT is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for all charges in full.

6. **Insurance Plan Participation/Out of Network Payments.** We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that (AHeARTT/Alliance for Healing) participates in your behavioral health plan. Out of network charges may have higher deductibles and copayments. If your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to AHeARTT immediately. Please contact your insurance carrier for more information.

7. **Referrals/Prior Authorizations.** If insured, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral/prior authorization for you to be seen by (AHeARTT/Alliance for Healing) it is your responsibility to be aware of this fact, and to obtain this referral or prior authorization. It is your responsibility to promptly assist our business office in any way needed, in obtaining such authorizations.

Account Balances & Payments-

8. **Collection of Unpaid Accounts.** If you have an outstanding balance over 60 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. You agree to pay AHeARTT for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs.

9. **Returned Checks.** Returned checks will be subject to a $40.00 returned check fee.

I have received and understand the Financial Policy of AHeARTT / Alliance for Healing

Patient Name (printed) _____

Patient Signature_____ Date_____

Relationship to Patient_____
(if patient is unable to sign or under the age of 18)

You may reach our business office by calling 651-493-8150 or emailing admin@aheartt.com

Assignment of Benefits

General Release of Information & Assignment of Benefits
I authorize AHeARTT/Alliance for Healing, on behalf of myself and/or my dependents, to furnish medical records, including files and other information related to services provided by AHeARTT, to my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes or health care operations. I hereby assign all authorized behavioral health benefits to which I am entitled, and I request payment of all such authorized benefits be made on my behalf to AHeARTT/Alliance for Healing for any services furnished by AHeARTT/Alliance for Healing.

Release of Information by Payers & Networks
I authorization to my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from AHeARTT/Alliance for Healing or any other provider, with AHeARTT/Alliance for Healing, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

Payment Agreement
I understand that I am financially responsible and agree to pay for any charges for the care and treatment rendered to me not covered by my insurance plan or if I do not have active insurance coverage.

Release & Retrieval of Information to/from Health Care Facilities & Providers
I authorize the release or retrieval of my medical treatment information and other information related to such services for behavioral health operations to or from other behavioral health facilities, and other providers who may be involved in my treatment for billing purposes.

I understand all the above and I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at any time and that my revocation shall have no effect on any actions taken prior to revocation.

I understand and acknowledge the Assignment of Benefits Policy of AHeARTT / Alliance for Healing

Patient Name (printed) _____

Patient Signature_____ Date_____

Relationship to Patient_____
(if patient is unable to sign or under the age of 18)

Notice of Privacy Practices Acknowledgment & Disclosure

The privacy of your information is important. We keep your information secure and confidential to the best of our ability. **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** guidelines are followed. For more information, you can request a copy of our ***Notice of Privacy Practices*** on HIPAA or visit their Web site at:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

By law we are considered a mandatory reporter. That means abuse to children/vulnerable persons must be reported. Actions must also be taken if there is considered to be imminent danger to self or others.

Initial_____

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty a Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warm the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental health care professionals are required to report admitted prenatal exposure to controlled substance that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested included, but it not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Patient Name (printed) _____

Patient Signature_____ Date_____

Relationship to Patient_____
(if patient is unable to sign or under the age of 18)

Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full session fee is charged for missed appointments or cancellations with less than a 24-hour (BUSINESS DAY) notice unless it is due to illness or an emergency. All Monday appointments need to be cancelled by the Friday prior to the appointment and or appointments following a holiday need to be cancelled the prior business day. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment. After three "NO SHOW" and or excessive late or last minute cancelled appointments, you will be discharged from our clinic and we will no longer see you as a patient.

Thank you for your consideration regarding this important matter.

I agree to the above cancellation policy and understand their meanings and ramifications.

Patient Name (printed) _____

Patient Signature_____ Date_____

Relationship to Patient_____
(if patient is unable to sign or under the age of 18)

Bill of Rights

Consumers of professional mental health services have the right:

(a) to expect that the professional consulted has met minimal qualifications of training and experience commensurate with service requirements and in accordance with professional and/or disciplinary standards.

(b) to be informed of the credentials of those by whom they are served;

(c) to be informed of the cost of professional services prior to receiving those services;

(d) to privacy as defined by rule and law;

(e) to be free from being the subject of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;

(f) to have access to their records as a provided in Minnesota Statutes, section 144.335 subdivision 2;

(g) and to be free from exploitation for the benefit or advantage of a therapist.