New Patient Registration Form-PARTNER/CONNIE TOAVS, LICSW 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

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 $198; individual rates are $130/45 minute hour or $156/60 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 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)