

# New Patient Registration Form SPOUSE/HOVEY



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:
<b>Spouse / Significant Other Information:</b>	
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:	<input type="checkbox"/> yes	<input type="checkbox"/> no	Phone:
	<input type="checkbox"/> yes	<input type="checkbox"/> no	E-mail:
	<input type="checkbox"/> yes	<input type="checkbox"/> no	Other:
Communication preference:	<input type="checkbox"/> E-mail	<input type="checkbox"/>	Phone: Home / Cell (circle one)
Do you wish to receive occasional <b>e-newsletters</b> 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.)			
<input type="checkbox"/> Yes <input type="checkbox"/> 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

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

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## 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 \$216; individual rates are \$155/45 minute hour or \$180/60 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

<b>Primary Insurance:</b>		Policy Holder:	Date of Birth:
Identification Number:		Group Number:	
Claims Address:			
City:	State:	Zip:	Phone:
<b>Secondary Insurance:</b>		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 \_\_\_\_\_