Future Foundation Services

3230 S. Buffalo Dr. #101 Las Vegas, NV 89117
888-337-4551 (Phone)

PATIENT REGISTRATION

(Information about the patient):

Date _____

NAME: _____ SEX ☐ Male ☐ Female

ADDRESS: _____
Street City State Zip

PHONE ( ) _____ DATE OF BIRTH _____ AGE _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ PHONE ( ) _____

SPOUSE'S NAME _____ _____

SPOUSE'S EMPLOYER _____ PHONE ( ) _____

FINANCIALLY RESPONSIBLE PERSON (If different from above)

Guarantor Name _____ Relationship to Patient _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Home Phone # _____ Work # _____

Employer _____ Occupation _____

PRIMARY INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____

Relationship to Patient _____ Insured's Employer _____

Insurance Co Name _____ Address _____

Policy Number _____ Group Number _____ Telephone # _____

SECONDARY INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____

Relationship to Patient _____ Insured's Employer _____

Insurance Co Name _____ Address _____

Policy Number _____ Group Number _____ Telephone # _____

Patient Name: _____

MEDICAL INFORMATION

FAMILY PHYSICIAN _____ PHONE ( ) _____

ADDRESS _____

PREVIOUS PSYCHIATRIC HISTORY _____

_____

EMERGENCY CONTACTS:

NAME _____ PHONE ( ) _____ RELATIONSHIP _____

NAME _____ PHONE ( ) _____ RELATIONSHIP _____

I authorize the release of any medical or other information necessary to process this claim. I hereby authorize Future Foundation Services and its related entities to apply for benefits on my behalf for the covered services rendered. I request that payment from my insurance company be made directly to Future Foundation Services and its related entities. I understand that I am responsible for any amount not covered by my insurance company. I certify that the information I have reported with regards to my insurance coverage is correct.

I permit that a copy of this authorization be used in place of the original. This authorization may be revoked in writing by either myself or my insurance company at any time.

_____ _____

Patient (Parent/Guardian) Signature Date

CANCELLATIONS

24-HOUR NOTICE REQUIRED
FOR CHANGES OR CANCELLATION

ALL SCHEDULING MAY BE HANDLED AT (888) 337 - 4551

I have read the above statement and I understand the instructions and my responsibility as a patient.

_____ _____

Patient (Parent/Guardian) Signature Date

LIMITS OF CONFIDENTIALITY

Everything you discuss with your case manager/therapist/psychiatrist/physician's assistant is confidential with the following exceptions:

*1. If you are a danger to yourself or others.
*2. If there is a reason to suspect child or elder abuse.
*3. If there is a reason to believe that an individual who is HIV positive is intentionally Trying to infect other
*4.If there is a reason to believe that there is prenatal exposure to controlled substances That are potentially harmful
5. If your records are subpoenaed.
6. If there is a third party payee, i.e. Medicaid, Medicare, Commercial Insurance, etc.

* Required to be reported to the proper authorities as mandated by law.

CONSENT FOR TREATMENT

I authorize and request my case manager/therapist/psychiatrist/physician's assistant to carry out psychological and/or psychiatric exams, treatment, and/or diagnostic procedures which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreements. I also understand that while the course of my treatment is designed to be helpful, my case manager/therapist/psychiatrist/physician's assistant can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my case manager/therapist/psychiatrist/physician's assistant and me. I, the responsible party, authorize the release on any information necessary to process insurance claims. I further understand that my case may be discussed in consultation for the purpose of optimal patient care.

_____ _____
Patient (Parent/Guardian)Signature Date

GENERAL CONSENT FOR CHILD OR DEPENDENT TREATMENT

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the case manager/therapist/psychiatrist/physician's assistant or group to deliver mental healthcare services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____ _____
Patient Name Date

_____ _____
Signature of Legal Guardian/Representative Date

CONSENT TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Before using or disclosing your protected health information to carry out treatment, payment, or healthcare operations, we are required under Federal law to obtain your consent. **By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment, of healthcare operations. This includes the release of your protected health information to pharmacies and other medical entities for the purposes of maintaining treatment.**

Our Notice of Privacy Practices (Notice) gives a complete description of the permissible uses and disclosures of your protected health information. Please note that we may change the privacy practices described in the Notice. If we change our Notice you may obtain a copy from the Operations Manager.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment or healthcare operations. We are not required to agree to such restrictions. However, if we agree to a restriction, such restriction will be binding.

You have the right to revoke this consent by submitting a written notice to this office, except to the event that we have taken action in reliance on your consent.

I have read this consent, and do hereby acknowledge the receipt of The Notice of Privacy Practices. I have read and understand my rights.

_____ _____

Patient Name Date/Time Notice Obtained

_____

Patient Signature (if applicable)

_____ _____

Patient Guardian/Representative Relationship to Patient

_____

Effective Date

*Client Name:*_____
*Date of Review:*_____

TREATMENT PLAN & REVIEW SIGNATURE PAGE

My signature below means that I have consented to the formulation of this treatment plan, understand, and approve of it, and accept the responsibility to carry out my part of the plan actively. I understand the need for services and each element of the treatment plan as presented. I understand this plan will be reviewed at least every 90 days or as requested if treatment needs change. I understand I have a right to receive a copy of the plan and have been offered a copy of the plan. As the identified client, I acknowledge the right to choose my provider and agree to the current providers assigned.

(This is a strictly confidential patient medical record. This report reflects the patient's condition at the time of consultation or evaluation. It does not necessarily reflect the patient's diagnosis or condition at any subsequent time.)

***Signature of Client** — **Date**

***Signature of Legal Guardian (if minor/incapacitated person)** — **Date**
☐ *Verbal consent was obtained from the legal guardian.*

***Signature of QMHP: Name, Credentials** — **Date**
☐ Developed plan

***Signature of Clinical Supervisor: Name, Credentials** — **Date**
☐ Same as QMHP signature above

Other Participant (Relationship:_____) — **Date**

Other Participant (Relationship:_____) — **Date**

Other Participant (Relationship:_____) — **Date**