Registration

dx_____

(PLEASE PRINT)

PATIENT NAME, Last_____First_____ **DofB**_____

I may contact you by e-mail, please print ***e-mail address***_____

Address_____City_____State_____ZIP_____

SSN_____ Employer _____

(SSN and/or Employer is required for certain 3rd-Party Payers)

Cell_____Home_____ Gender Male

NOT OK to leave message____ **NOT OK** to leave message____

RESPONSBILE PERSON – if other than patient. If patient's name is NOT on insurance card or EAP authorization, you must provide insurance subscriber's or employee's full name and date of birth

Last Name_____First_____ **DofB**_____

Address_____City_____ State_____ ZIP_____

SSN_____ Employer _____

(SSN and/or Employer is required for certain 3rd-Party Payers)

Cell_____Home_____ Gender Male

NOT OK to leave message____ **NOT OK** to leave message____

INSURANCE / EAP _____GROUP #_____

ID #_____ Authorization #_____

EMERGENCY CONTACT_____

You consent for this person to be contacted during any emergency as defined by William Lafayette, LMFT

Phones, Cell_____Home_____Work_____

HOW DID YOU HEAR OF MY SERVICES?_____

HAVE YOU HAD PRIOR COUNSELING? Yes No If *Yes,* briefly describe what was helpful about it?

_____

AGREEMENT TO POLICIES

I have been given the Policies brochure. I understand and agree to the **Financial Agreement, Cancellation/Late/No-Show, Photo IDs / Insurance Cards, 3rd-Party Payer Release and Assignment, Contract and Consent, Mandatory Disclosure, Minor Patient(s), Privacy Policy, Authorization & Referral, Release of Information, Court / Litigation, Acceptance of Agreement** as well as the **Emergency Contact** provision.

_____ _____

Patient or Responsible Party Signature Date

William H. Lafayette Jr., M.A., LMFT

1400 Main Street, Suite 176, Clarksville, IN 47129-3108

502-741-3081 f 855-869-7122

Lafayette.lmft@gmail.com

PATIENT BACKGROUND

This information is necessary for me to provide services to you. If you don't understand any area or any area makes you uncomfortable, please bring it to my attention when we meet.

Name_____ Birthday_____ Date: _____

1 Why are You Seeking Help?

_____

2 Primary Care Physician and Contact Information

_____

3 History of Mental Health Problems?	O Yes	O No	O Don't Know
Hospitalized?	O Yes	O No	O Don't Know
Outpatient Treatment	O Yes	O No	O Don't Know
On Medications	O Yes	O No	O Don't Know
History of Violence or Suicide Attempts	O Yes	O No	O Don't Know
Thoughts about Suicide or Violence	O Yes	O No	O Don't Know
Other	O Yes	O No	O Don't Know

If **Yes** to Any, Please Tell Me More

_____

4 Problems in Functioning?	O Yes	O No	O Don't Know
School	O Yes	O No	O Don't Know
Work	O Yes	O No	O Don't Know
Family	O Yes	O No	O Don't Know
Peers	O Yes	O No	O Don't Know
Social Activities	O Yes	O No	O Don't Know
Eating	O Yes	O No	O Don't Know
Sleeping	O Yes	O No	O Don't Know
Day-to-Day Activities	O Yes	O No	O Don't Know
Other	O Yes	O No	O Don't Know

If **Yes** to Any, Please Tell Me More

_____

5 Current Legal, Probation, Parole Problems? O Yes O No O Don't Know

If **Yes**, Please Tell Me More

_____

6 Current Medical Problems?	O Yes	O No	O Don't Know
On Medications	O Yes	O No	O Don't Know
Recently Hospitalized	O Yes	O No	O Don't Know
Under Care of Health Care Professional	O Yes	O No	O Don't Know
Other	O Yes	O No	O Don't Know

If **Yes** to Any, Please Tell Me More

_____

7 History of Medical Conditions	O Yes	O No	O Don't Know
Drug Allergies	O Yes	O No	O Don't Know

Tell Me More About Your Medical Conditions

_____

PATIENT BACKGROOUND

Client_____ Birthday_____ Date: _____

8 Domestic Violence History ○ Yes ○ No ○ Don't Know
If **Yes**, Please Tell Me More

_____

9 Alcohol Use ○ Yes ○ No ○ Don't Know
If Yes, Last Date Consumed _____/_____/___ Amount Consumed _____ What?_____
Any Increase in Tolerance ○ Yes ○ No ○ Don't Know
Blackouts ○ Yes ○ No ○ Don't Know
Tell Me More About Your Alcohol Use

_____

10 Drug Use ○ Yes ○ No ○ Don't Know
If Yes, Last Date Consumed _____/_____/___ Amount Consumed _____ What?_____
Any Increase in Tolerance ○ Yes ○ No ○ Don't Know
Tell Me More About Your Drug Use

_____

11 Chemical Dependency Treatment ○ Yes ○ No ○ Don't Know
If **Yes**, Please Tell Me More

_____

12 Disabled ○ Full ○ Partial ○ No ○ Don't Know
If **Yes**, Please Tell Me What Type and More

_____

↔↔↔↔↔↔↔↔↔↔↔↔↔↔DO NOT WRITE BELOW THIS LINE ↔↔↔↔↔↔↔↔↔↔↔↔↔↔

13 Strengths/Assets

_____

14 Preliminary Assessment

_____

15 Preliminary Dx (s) _____

16 Accepted for Treatment ○ Yes ○ No Further Evaluation ○ Yes ○ No

17 If Not Accepted, Referred To and Why:

_____

18 Initial Treatment Goals: _____

19 Initial Prognosis: _____

20 Other Relevant Information _____

Therapist Signature: _____ Date_____

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RELEASE OF INFORMATION

All patients with 3rd-party payers MUST make a choice below and sign this form.

Patient_____ DOB_____

1. I understand that most 3rd-party payers **require** William H. Lafayette Jr., M.A., LMFT, to inform my primary care practitioners, psychiatrists, or care professionals that I am receiving psychotherapy -- **unless I opt-out of that requirement by marking the line immediately below.**

   ↓

   _____ *At this time*, I do not want William H. Lafayette Jr., M.A., LMFT, to contact any care professional regarding my psychotherapy.

or

2. I want William H. Lafayette Jr., M.A., LMFT, to communicate with the entity named below. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This authorization shall be valid for the length of treatment with William H. Lafayette Jr., MA, LMFT, or until canceled by me. I hereby relieve and release the below mentioned from any and all damages, claims and causes of action arising out of, or in connection with the release of this information. I agree that a photocopy of this form may be used in lieu of the original.

   ↓

   _____ I authorize and consent for William H. Lafayette Jr., M.A., LMFT, to release, obtain and consult by written, verbal or electronic communication with:

   Doctor, Lawyer, Agency Psychiatrist, Facility, etc. from whom information is to be sent or received (Use A Separate Form for Each and Every Contact):

   Name _____

   Address

   _____

   Phone _____ Fax _____

_____ _____

Patient / Responsible Party Signature Date

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PAYMENT AUTHORIZATION

(Debit, Flexible Spending, Health Savings, Master Card, VISA, Discover, AmEx)

Fee payment is a normal, necessary and expected part of a patient-therapist relationship.
Contract obligations with 3rd party-payers require me to collect from patient non-paid allowable charges.
This allows us to have proper, appropriate, & timely payment for allowed charges.

I authorize William H. Lafayette Jr., M.A., LMFT, to keep my signature on file and to use my card for balances remaining after claims are resolved with insurance companies.

This Authorization shall be valid for the length of treatment with William H. Lafayette Jr., M.A., LMFT, or until canceled by me.

All transactions are electronic, no paper receipt is available from me. A receipt may be sent to you by the card processor OR provide me with the e-mail address associated with the card:

_____@_____.com

The following are covered under this Payment Agreement:

Name *(print)*_____

Name *(print)*_____

_ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _

Card Number

_ _ / _ _ _ _ _ _ _ _ _ _

Expiration Date Month Year | 3 Numbers on Back of Card | ZIP Code Where Card Statement is Sent

CARDHOLDER Name *(print)*_____

CARDHOLDER Signature_____ Date_____

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