PATIENT INFORMATION & REGISTRATION FORM

Date: _____

Patient Name: _____
Last ***First*** ***Middle Initial***

SS#: _____ ***DOB:*** _____ ***Age:*** _____ ***Sex:*** _____

Address: _____

City/State/Zip: _____

Home Phone: _____ ***Work Phone:*** _____

Employer: _____ ***Occupation:*** _____

Work Address: _____
_____

Other Family Members at Home:

Name	***Age***	***Relationship***

Current Medical Physician: _____

Medication currently taking: _____

In Case of Emergency, Please Notify: _____

Address: _____ ***Phone:*** _____

Relationship: _____

Reason for seeking counseling today: _____

_____

Referred by: _____

In the event of an emergency, which I am not available, I understand that I am to report to the nearest emergency room or mental health facility for services.

Signed: _____ ***Date:*** _____

INSURANCE INFORMATION

Responsible Person/Subscriber:

Name:_____
Last First Middle Initial

DOB:_____ SS#:_____

Address:_____ Phone:_____

Employer:_____ Address:_____

Relationship to Patient:_____

ID#:_____ Group#:_____

Insurance Company:_____

Phone#:_____ Address:_____
_____

Do you have a secondary insurance?: Yes_____ No_____

Name:_____ ID#:_____

I authorize the release of any medical and/or mental health information necessary to process my insurance claim.

Signature: _____

I understand that I will be responsible for any charges not covered by insurance, regardless of the insurance policy. I agree to give 24 hours notice if I am unable to make an appointment, and I understand that I will be charged for missed sessions if I do not provide such notice.

Signature: _____ Date: _____

Witness: _____ Date: _____

CONFIDENTIALITY

I Place a high value on the confidentiality of the information that my clients/patients share with me. This sheet was prepared to clarify my legal and ethical responsibilities regarding this important issue.

Personal information that you share with me may be entered into your records in written form. However, an effort is generally made to avoid entry of information that may be especially sensitive or embarrassing. I am the only individual with access to my file or staff that may be performing related clerical tasks. Any person who may have access to your file, other than myself is aware of the strict confidential nature of the information in the records. Persons from outside my office are not allowed access to my files. Please note however, that insurance companies and managed care companies may request to inspect any information contained in your file and I am responsible to obtain this information for them.
I also use an outside billing company to bill the insurance companies on my behalf. Information shared is used for billing purposes only and does not contain information from the files other than the insurance information.

RELEASE OF INFORMATION TO OTHERS

If, for some reason there is a need to share information in your record with someone not employed here (for example, your physician, other therapist or an insurance company, you will first be consulted and asked to sign a form authorizing the transfer of the information. Because of the sensitive nature of the information contained in some records, you may wish to discuss the release of this material and related implications very carefully before you sign. The form will specify the information, which you give to me and gives me permission to release to the other party and will specify the time period during which the information may be released. You can revoke your permission at any time by simply giving a written notice.

EXCEPTIONS TO CONFIDENTIALITY

There are several important instances when confidential information may be released to others. First if the Court (court ordered) has referred you to this agency, you can assume that the Court wishes to receive some type of report or evaluation. You should discuss with my exactly what information might be included in a report to the Court BEFORE you disclose any confidential material. In such instances you have a right to tell what you want me to know.

Second, if you are involved in litigation of any kind and inform the court of the services that you receive from me (making your mental health an issue before the court) you may be waiving your right to keep your records confidential. You may wish to consult your attorney regarding such matters before you disclose that you have received treatment.

Third, if you threaten to harm either yourself or someone else and I believe your threat to be serious, I am obligated under the law to take whatever actions seem necessary to protect people from harm. This may include divulging confidential information to others and would only be done under unusual circumstances where someone's life appeared to be in danger.

Fourth, if I have reason to believe that you are abusing or neglecting your children, I am obligated by law to report this to the appropriate state agency. The law is designed to protect children from harm and the obligations to report suspected abuse or neglect is clear in this regard.

In addition there may be some rare instances in which you waive your rights to have your records protected. If you are involved in any type of current or potential legal difficulties, I suggest that you discuss such matters with your attorney before informing others of the services you have received here.

In summary, I make every reasonable effort to safeguard the personal information, which you may share with me. There are however, certain instances when I may be obligated under the law to release such information to others. If you have any 1questions about confidentiality, please discuss them with me.

I have read and understand the policy on confidentiality.

_____ _____

Signature ***Date***

_____ _____

Minor Signature ***Date***

_____ _____

Witness ***Date***

As a parent or guardian of the above minor child or client, I voluntarily give my permission for his/her treatment as a client.

_____ _____

Parent/Guardian ***Date***

CONSENT FOR TREATMENT

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to and authorizes services by Heather Fewox-Steen, LMHC`. These services may include psychotherapy and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. ***Be informed of and to participate in the selection or treatment services.***
2. ***Receive a copy of this consent and,***
3. ***Withdraw this consent at any time.***
4. ***Be referred to another professional if requested.***
5. ***Any inactivity for more than 90 days and the file will be closed.***

_____

Date

_____

Signature of patient

_____

Signature of parent, legal guardian or conservator

_____

Signature of Witness

PLEASE CHECK ANY OF THE FOLLOWING WHICH ARE CURRENT CONCERNS:

__ ***Moodiness***

___ ***Can't Concentrate, thoughts racing***

___ ***Confused***
___ ***Depressed***

___ ***Suicidal thoughts***

___ ***Anxious, feeling panicky***

___ ***Feeling angry***

___ ***Feeling inferior, no self confidence***

___ ***Worried, fearful***

___ ***Sensitive, feelings easily hurt***

___ ***Unhappy***

___ ***No feelings at all***

___ ***Difficulty separating from my family, having my own identity***

___ ***Weight change __gain ___loss***

___ ***Problems with eating***

___ ***Difficulty in sleeping __too much ___too little***

___ ***Lack of energy, tired all the time***

___ ***Headaches***

___***Overuse of drugs, alcohol, or medication***

___ ***Dizziness, fainting***

___ ***Nightmares***

___ ***Stomach Trouble***

PLEASE CHECK ANY OF THE FOLLOWING WHICH ARE CURRENT CONCERNS:

___ *Constipation/diarrhea*

___ *Fast heart beat*

___ *Frequent sweating*

___ *Muscles jumping*

___ *Chronic health problems*

___ *Cold hands, cold feet*

___ *Sexual Concerns*

___ *Shy with People*

___ *Feeling lonely*

___ *Conflict in interpersonal relations- Fighting*

___ *Difficulty relating to people, making friends*

___ *marital concerns*

___ *Problems with children*

___ *Problems with parents, family*

___ *Problems with aging family member*

___ *Dealing with death or loss*

___ *Phobias*

___ *Career indecision*

___ *Difficulties at work*

___ *Concern about finances*

___ *Difficulties with school*

___ *Poor time management*

I would like to accomplish the following with therapy:

___ *Increase awareness of my own feelings*

___ *Develop coping skills*

___ *Clarify personal goals and values*

___ *Have more realistic self expectations*

___ *Eliminate problematic behaviors*