New Client Registration

Welcome! Please read and complete the following 6 pages.

Today's date: _____

Patient's name _____ **Date of birth** _____ **Age** _____
(First) (Middle) (Last)

Street Address _____ **Apt.** _____

City _____ **State** _____ **Zip** _____

Phone number(s): Home (_____)_____Work (_____)_____ Cell (_____) _____
Is it OK to call you at any of your listed phone numbers? ____ Yes _____ No …If no, please explain _____
_____

Gender: Male / Female **Marital status:** Married / Single / Sep. / Divorced / Widowed **How long?** _____

Social Security # _____ **Driver's Lic. #** _____

Employer _____ **Job position / title** _____

Work address _____ **City** _____ **State**_____ **Zip**_____

Grade_____ **School** _____
How did you hear about us? ___ Sign ___ Insurance Co. ___Family / Friend ___Yellow pgs. ___ Doctor
____ web page _____ Internet search Other: _____

****If the patient is a minor child, we need the following information****
Mother's name (or legal guardian) _____ **DOB** _____
Address (if different from patient's) _____
City _____ **State** _____ **Zip** _____
Phone #'s: Home _____ **Cell** _____ **Work** _____
Social Security # _____ **Employed:** Full time / Part-time / Not employed
Employer's name and address: _____
_____
Father's name (or legal guardian) _____ **DOB** _____
Address (if different from patient's) _____
City _____ **State** _____ **Zip** _____
Phone #'s: Home _____ **Cell** _____ **Work** _____
Social Security # _____ **Employed:** Full time / Part-time / Not employed
Employer's name and address: _____
_____
If parents live at separate addresses, which address do we use for statements? Mother / Father
Who is the custodial parent for the child? Mother / Father / Joint

<u>Insurance Information – Please provide your insurance card a copy can be made for the chart :</u>

Name of insured _____ **Relationship to patient:** Self / Spouse / Parent / Other:_____
Address of insured _____
(or indicate "same as mother" or "same as father" and etc.) Insured's DOB _____ **Gender: M / F**
Name of employer / group that insurance is supplied through _____
Street address _____ **City** _____ **State** _____ **Zip** _____
Ins. ID # _____ **Group #** _____
Phone # to verify benefits _____

Medical Information:

Patient's Primary Care Physician _____ **Phone #** _____
Physician's address_____ **City** _____ **State** _____ **Zip** _____

Please list any other current medical or health problems as well as the treatment provider(s) working with you:

_____
_____
_____

List any medications that you are currently taking or have taken in the past 6 months, condition being treated, and physician:

Medication	Mg. / Dosage / How often?	Condition Treated	Physican	Taking now?
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

Other: _____

Personal Information:

Patient's highest grade completed _____ **School(s) / Degrees(s)** _____

List any other persons residing in the household:

Name	Age	Relationship to patient

Patient's nearest relative not living in home (in case emergency): Name _____ **Relation**_____
Home ph. # _____ **Cell #** _____
Address _____ **City** _____ **State** _____ **Zip** _____

Briefly describe the problem(s) for which you are seeking help today? (use reverse side if you need more room):

_____
_____
_____
_____

If you (or your child) are currently experiencing any of the following to the point where you / they feel troubled or bothered – circle the item(s). Please place a check mark next to any symptoms that you may not be experiencing currently, but which have been significant or problematic in the past:

Aggressiveness / Anger	Drug abuse	Paranoid feeling	Sexual problems
Alcohol abuse / Addictions	Excess Stress	Parent – Child problem	Sleep problems
Anxiety / Nervousness	Hallucinations	Poor concentration	Strong fears
Confusion	Homicidal thoughts	Poor appetite	Suicidal thoughts
Death of a loved one	Hopelessness	Poor memory	Very low energy
Depression	Legal problems	Recent lifestyle change	Weight loss
Disorientation	Marital / Relationship problems	Restlessness	Weight gain
Divorce	Panic attacks	School problems	Work problems

Other(s)_____

If you think alcohol or substance is or could be a concern for yourself or someone else in your household, please explain who you have concern for, substance(s) used, and level of use: _____

_____

_____

Have you ever received counseling or psychotherapy before? Yes ____ No _____ If yes, what did you seek help for? _____

_____

_____

Do you feel like you benefited from this experience? Yes ____ No _____ Please explain: _____

_____

Please list name(s) of any previous counselors, therapists, or psychiatrists and dates seen (approximate if necessary): _____

_____

_____

Has anyone else in your household ever received counseling / psychotherapy / inpatient psychiatric hosp. /substance abuse trx ? Yes _____ No _____ If yes, please explain: _____

_____

_____

PLEASE READ CAREFULLY AND SIGN AT THE CONCLUSION OF THE FOLLOWING INDICATING THAT YOU HAVE BEEN INFORMED OF THE POLICIES LISTED HEREIN AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND/OR REQUEST CLARIFICATION:

Payment and Insurance Reimbursement Policy:

Patients are required to pay all fees in full at the time service is provided unless other arrangements have been made in advance and in writing with your therapist. If you have insurance that will cover our services, I am generally willing to file claims once insurance coverage has been verified. Your insurance company may also require you to obtain pre-authorization for services. If you desire for your therapist to file claims for you, you will be required to sign the "assignment of benefits" statement below and pay any required co-payment at the time of your visit. If you have an unmet insurance deductible, you will be required to pay for services in full until your deductible is satisfied. If you desire, a completed insurance form can be provided for you so that you can file claims yourself with your insurance company. If you are covered by secondary insurance, I can provide you with the necessary paperwork to file with the secondary insurer. I generally do not file secondary claims unless arrangements have been made in advance.

Please note that it is the patient or adult parent / guardian's responsibility to be or get familiar with the insurance benefits as necessary including but not limited to obtaining any pre-authorization required for initial or subsequent visits, as well as verifying coverage and any applicable limits. It is important to realize that, regardless of any insurance coverage that is quoted by your insurance company, it is the patient (or adult parent / guardian) who will ultimately be responsible for payment for services provided. I will attempt to accommodate your insurance needs – however, if payment is denied, you will be held responsible for the charges incurred.

Payments are generally accepted in the form of cash, check, or charge / debit card (Visa, Mastercard, Discover, Amex). Checks should be made payable directly to Robin W. Dunn, MS, LPC. A $20.00 fee will be added to your account in the event a check is returned by the bank for insufficient funds. In the event of default of payment, your account may be turned over to a collection agency which may require disclosure of confidential information. In most collection situations, the only information released in the patient's name, responsible party's name, identifying date(s), nature of services provided and the amount(s) due. If your account is delinquent, you may be assessed a reasonable collection fee in addition to the final amount owed. In addition to this, the collection agency is also entitled to and may apply reasonable collection charges and/or attorney's fees or court costs.

Assignment of Benefits:

I authorize release of any treatment or patient information necessary to process insurance claims. I also authorize payment of insurance benefits to be made to Robin W. Dunn, M.S., L.P.C. - for services provided.

Signed _____ Date _____

Relationship to patient: Self / Parent / Guardian

Provider – Patient Services Agreement:

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations. HIPAA requires that provide you with a Notice of Privacy Practices (Georgia Notice Form) for use and disclosure of PHI for treatment, payment, and health care operations. The notice, which is attached to this document, explains HIPAA and its application to your personal health information in greater detail. The law requires that we your signature acknowledging that you have been provided with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you may have about the procedures. When you sign this document, it will represent an agreement between you and your therapist. You may revoke this agreement in writing at any time. Any revocation by you will be binding on me with the exceptions of any action your therapist may have already taken in reliance on your prior approval, or if there are obligations imposed on your therapist by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you incurred. In general, after a suspension of treatment of 30 days or more, your chart will be closed unless other arrangements have been specified in advance.

Psychological Services:

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, the age of the patient, the particular problem(s) being experienced, and other factors. There are many different theoretical approaches that can be pursued to deal with the problems that you hope to address. The process of therapy will call for active effort and participation on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during sessions and at home. Psychotherapy can have many benefits, but can also include risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have many merits and benefits. Therapy can lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Despite our belief in the process of psychotherapy and its potential to help, we cannot make any guarantee of what you will experience or that you will attain the goals you set. Your therapist can pledge to work diligently and respectfully in attempting to assist you.

Appointments and Cancellations:

Appointments are generally 45 - 50 minutes in length, and may be recommended weekly, or with greater or lesser frequency depending on your needs and sometimes on the basis of appointment availability.

Please note that it is not my policy to double-book appointments. Any appointment times you set are committed exclusively to you. When an appointment is missed or rescheduled on short notice, my schedule is disrupted and I am then unable to make the appointment time available to other clients. For this reason, a full 24 hour notice is required of your intent to cancel or reschedule an appointment. If you cancel or opt to reschedule an appointment without giving a full 24 hour notice, or if you miss an appointment altogether, please be aware that you will be charged the full contracted rate that would have been collected for the hour you reserved (i.e. your full hourly fee / the total amount ins would pay, not just your co-payment amount).

Charges for missed appointments cannot be filed with your insurance carrier, and will be billed directly to the patient or responsible party as applies. Payment is due within one week of the missed appointment unless other arrangements have been made.

Contacting Your Therapist:

Due my busy schedule, I may not be immediately available by telephone or if you were to stop by the office without an appointment. I will not be able to take calls or in-person visits from you while actively in session with another client who has an appointment. When I am unavailable, the telephone will be answered by a confidential voicemail. I will generally be able to, and will make effort to return phone calls within 24 hours of receiving them with the exception of weekends and holidays. However – I cannot guarantee a return call within a specific time-frame at any time. If you are having an emergency, you can call your my office number / cell number and leave a message. If the emergency is life threatening or you feel you cannot wait for a return call – you also always have the options of either calling 911or going to your nearest emergency room as appropriate. If I will be unavailable for an extended period of time such as can occur with a vacation, I may designate an on-call therapist to cover in case of emergencies and/or I may be reachable by cell phone. You should clarify emergency procedures with me directly if you have any questions.

Limits on Confidentiality:

The law protects the privacy of all communications between a patient and a therapist. In most situations, your therapist can only release information about your treatment if you sign a written authorization form that meets legal requirements imposed by HIPAA. **There are other situations that require only that you provide written, advanced consent. Your signature on this agreement provides consent for these activities as follows (continued on next page):**

* Your therapist may occasionally find it helpful to consult with other health and/or mental health professionals about a case. During a consultation, every effort will be made to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information shared confidential. If you do not object, your therapist will likely not tell you about such a consultation unless they judge that it is somehow important to your progress in treatment. Your therapist will note all relevant information consultations in your Clinical Record – which is also referred to as PHI in our Notice of Policies and Practices to protect the privacy of your health information.

* You should be aware that your therapist practices with other mental health professionals and that he/she may employ administrative staff. He/she will need to be able to share protected information with these individuals for both clinical and administrative purposes such scheduling, billing, and quality assurance. Any other mental health professionals are bound by the same rules of confidentiality. Any staff member will have been given training about protecting your privacy and have agreed not to release information outside of the practice without permission of a professional staff member.

* Your therapist has contracts with Health Insurance Carriers and/or Managed Healthcare Companies. As required by HIPAA, he/she has a business associate contract with such companies wherein they promise to maintain confidentiality of this data except as allowed in the contract or otherwise required by law.

* If a patient threatens to harm himself / herself, or threatens to harm someone else – your therapist may be obligated to seek hospitalization and/or call 911 as judged appropriate, and / or to contact family members or others who could help provide protection for the patient or others as judged appropriate.

There are some situations where your therapist is permitted to or required to disclose information without either your consent or authorization. The situations are:

* If you are involved in a court proceeding and a request is made for information concerning professional services provided for you by your therapist. Such information is protected by the therapist – patient privilege law. Your therapist cannot provide any information without your written authorization unless they are ordered to by a court of law. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether the court would be likely to order your therapist to disclose information about you and/or your treatment.

* If a government agency is requesting the information for health oversight activities, your therapist may be required to provide it.

* If a patient files a complaint or lawsuit against a therapist, he/she may disclose relevant information regarding that patient in his/her defense.

* If a patient files a worker's compensation claim, then the treating therapist must, upon appropriate request – furnish copies of all records, reports, and bills.

There are some situations in which your therapist is legally obligated to take actions which they believe are necessary to attempt to protect others from harm. In the process, he/she may have to reveal some information about a patient's treatment. Though possible, such situations tend to be unusual in practice. These situations are:

* If your therapist has reason to believe that a child has been abused, the law requires that he/she file a report with the appropriate governmental agency, usually the Georgia Department of Family and Children's Services. Once such a report is filed, he/she may be required to provide additional information as required by law.

* If your therapist has reasonable cause to believe that a disabled adult or elderly person has been physically or emotionally abused (other than by accidental means), or has been neglected or exploited, he/she must file a report with an agency designated by the Department of Family and Children's Services. Once such a report is filed, he/she may be required to provide additional information as required by law.

* If your therapist determines that a patient presents a serious danger of violence to someone else, your therapist may be required to take protective actions. These actions may include notifying the potential victim(s), contacting family members or friends, contacting the police, and/or seeking hospitalization for the patient.

If any of the situations listed above were to occur, your therapist will make every effort to fully discuss it with you before taking any action unless it is not advisable clinically to do so. Your therapist will also attempt to limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that discuss any questions or concerns that you may have now or in the future.

Professional Records:

The laws and standards of your therapist's profession requires that PHI about you be recorded in your Clinical Record. You may examine and/or receive a copy of your clinical record with a written request with the exception of circumstances that involve danger to yourself and/or others, or if reference is made to another person and your therapist believes that access is reasonably likely to cause substantial harm to such other person, or where information has been supplied to your therapist confidentially by others. Because these are professional records, it is possible that they could be misinterpreted or otherwise lead to upset in untrained readers. For this reason, it is generally advisable for you to review your records in the presence of your therapist or to have them forwarded to another licensed mental health professional so that the contents can be discussed with you in an appropriately informed manner. In most situations, your therapist is allowed to charge a copying fee of $50 per record. If your therapist refuses your request for access to your records, you have a right of review (except not applying to information provided confidentially to your therapist by others) which your therapist can discuss with you upon request. In addition to your Clinical Record, your therapist may also keep a set of Psychotherapy Notes. These notes are for the therapist's own use and are designed to assist your therapist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from patient to patient, they can include the contents of conversations with the therapist, your therapist's analysis of such conversations, and similar information. Psychotherapy Notes may also contain information that in not required to be included in your Clinical Record and/or information supplied to me confidentially by others. These Psychotherapy notes are not available to you and cannot be sent to anyone else including insurance companies without your signed authorization. Insurance companies are prohibited from requiring your authorization to release such information as a condition of coverage, nor can they penalize you in any way for your refusal to provide it.

Patient's Rights:

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that your therapist amend your record, requesting restrictions on what information from your clinical record is disclosed to others, requesting an accounting of most disclosure of protected health information that you have neither consented to nor authorized, determining the location to which protected information disclosures are sent, having any complaints you make about your therapist's policies and procedures recorded in your records, and the right to a paper copy of this Agreement including my privacy practices or Notice of Policies and Practices. Your therapist will be willing to discuss any of these rights with you.

Minors and Parents:

For patients under 18 years of age who are not emancipated, parents and/or legal guardians are allowed by law to examine their child's treatment records unless the therapist believes that doing so would endanger the child. Because privacy in psychotherapy is often crucial to successful progress, particularly with but not limited to teenagers, your therapist's policy is to have an agreement with parents that they consent not to ask for access to their child's records unless all parties involved agree to allow it. If the minor agrees, during treatment your therapist will provide general information about progress in treatment and his/her attendance at scheduled sessions. Your therapist can also provide a summary of the child's treatment once it is complete upon request. If at any point during treatment your therapist believes that the child is in danger or is a danger to someone else, the parent(s) and/or guardian(s) will be notified.

Insurance Reimbursement and Confidentiality:

You should also be aware that if you are using insurance, your contract with your health insurance company requires that your therapist provide information relevant to services that are provided for you. Your therapist will typically be required to provide a clinical diagnosis, and sometimes treatment plans or summaries, and in rarer cases even copies of your entire clinical record. In such situations, your therapist will make every effort to release only the minimum information about you that in necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in computer files. Though all insurance companies claim to keep such information confidential, your therapist will have no control over what an insurance company does even with confidential PHI once it is provided to them. It is possible that your PHI could be shared with a national medical information databank. Your therapist can provide you with a copy of any report submitted should you request it. After insurance coverage details are verified, you and your therapist can discuss what you can expect to accomplish with the benefits that are available and what will happen if your benefits expire before you feel ready to end your treatment. It is important to remember that you always have the right to pay for services yourself if you feel you need to or want to continue treatment.

Consent to Treatment:

I consent to have **Robin W. Dunn, M.S., L.P.C.** provide psychological evaluation, psychological counseling, and/or related mental health treatments for myself and/or my minor child. My signature below indicates that I have read and understand the information regarding payment and insurance reimbursement, assignment of benefits, provider – patient services agreement, psychological services, appointments and cancellations, contacting your therapist, limits on confidentiality, professional records, patient's rights, minors and parents, insurance reimbursement and confidentiality, and consent to treatment all of which are contained on the preceding pages of this document. By signing, I am agreeing that I have had the opportunity to ask questions, and that I will abide by all of the terms and policies contained herein in their entirety during our professional relationship. Additionally, the information I have provided regarding my history and condition is true and complete to the best of my knowledge.

_____ _____

Client's signature (or legal guardian) **Date**