***50px-Psy_symbolTREASURE VALLEY PSYCHOLOGICAL SERVICES***

**PATIENT REGISTRATION FORM**

**YOUR SIGNATURES/INITIALS INDICATE YOU HAVE READ AND UNDERSTAND THE INFORMATION WITHIN THE FORM SECTION YOU ARE SIGNING.**

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| **PATIENT INFORMATION** (This section refers only to the patient) | | | | | | | | | | | | | | | | | | |
| Name |  | | | | |  | Gender/Age |  | | | / |  |  | Birth Date | |  | |  |
| Street Address | | | |  | | | | | | | | |  | Race |  | | |  |
| City, State & Zip | | | |  | | | | | | | | |  | Ethnicity |  | | |  |
| Home Phone | | |  | | |  | Marital Status | |  | | | | | | | | |  |
| Cell Phone | | |  | | |  | Soc Sec Num | |  | | | | | | | | |  |
| Work Phone | | |  | | |  | Occupation | |  | | | | | | | | |  |
| *Primary Care Doctor* | | | | |  |  | Referred By | |  | | | | | | | | |  |
| E-Mail | |  | | | | | |  | | Last Grade Completed | | | | | | |  |  |
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| **BILLING INFORMATION** (Person responsible for bill/payment) | | | | | | | | | | | **Check here if patient is responsible**. | | | | | | | |
| Name | |  | | | | | |  | Birth Date | |  | | | | | | |  |
| Mailing Address | | | | |  | | | | | | | | | | | | |  |
| City, State & Zip | | | | |  | | | | | | | | | | | | |  |
| Home Phone | | | |  | | | |  | Cell Phone | | |  | | | | | |  |
| Relationship to patient | | | | | |  | |  | Soc Sec Num | | | |  | | | | |  |
| Employer | | |  | | | | | | | | | |  | Work Phone | | |  |  |
| Alternate Mailing Address for Statements | | | | | | |  | | | | | | | | | | |  |
| City |  | | | | | | |  | ST |  | | | | |  | Zip |  |  |
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| **INSURANCE INFORMATION** | | | | | | | | | | | **Check here if NO COVERAGE.** | | | | | |
| **Please read & initial by the following 3 statements to indicate you have read them**. | | | | | | | | | | | | | | | | |
|  |  | 1. If your coverage depends on a doctor’s referral, it is **YOUR** responsibility to obtain it. | | | | | | | | | | | | | | |
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|  |  | 2. Please list information for ALL insurance coverage for the patient. Failure to provide this information may result in your being liable for claims denied by your insurance company for “failure to file claim in a timely manner.” | | | | | | | | | | | | | | |
|  |
|  |  | 3. It is your responsibility to check your insurance policy for “co-pay” or “deductible/coinsurance,” and “waiting periods” or “pre-existing condition” clauses that may result in claim denial. | | | | | | | | | | | | | | |
|  |
| Primary Insurance Company | | | | |  | | | | | | | | | | |  |
| Policy/Member Number | | | |  | | | |  | Group Number | | |  | | | |  |
| Policy Holder | | |  | | |  | Birth Date | | |  | | |  | Soc Sec # |  |  |
|  | | | | | | | | | | | | | | | |  |

***If applicable, please complete “SECONDARY INSURANCE”***

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| Secondary Insurance Company | | |  | | | | | | | | | |  |
| Policy/Member Number | |  | | | |  | Group Number | |  | | | |  |
| Policy Holder |  | | |  | Birth Date | | |  | |  | Soc Sec # |  |  |
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**ADDITIONAL INFORMATION**

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|  | Names & Ages of Immediate Family Members (demographics): |  |  |
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|  | Drugs/Medications Presently Being Used: |  | See Attached List | |
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|  | Medical/Health History (brief summary of history that could affect counseling/therapy): |  |  |
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\*\***Please read & initial statements below concerning claims & billing, indicating you have read them.**

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| --- | --- | --- | --- | --- | --- |
| \_\_\_\_\_ | 1. We will bill the insurance company. If the insurance company does not pay, the patient/guarantor is ultimately responsible for payment of claim. A diagnosis code is required to bill insurance. If you do ***NOT*** want a diagnosis in your records, you will be required to pay our full charge for each session. | | | |  |
|
| \_\_\_\_\_ | 2. Co-payment is due at the time of service. Deductible, Co-insurance, Non-covered Procedures, etc, will be payed by the end of the month in which you receive the Balance Due statement (mailed out during the first week of each month.) Failure to pay the Balance Due could result in your account being sent to Collections. Collection agencies may request your records/confidential information. Timely payment of amounts due will help avoid this possibility. | | | |  |
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|  | **I accept responsibility for the full charge of each session in which I request omission of** | | | |  |
|
|  | **diagnoses codes from my record.** |  | | |  |
| **SIGN ONLY IF ACCEPTING FULL PAYMENT OPTION** | | |  |

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|  | In order for us to submit a claim for payment to us for services under your policy, we must have your authorization to release medical information to your insurance company. | | |  |
|  | **I hereby authorize release of information necessary to file a claim with my insurance company, and ASSIGN BENEFITS, OTHERWISE PAYABLE TO ME, TO THE PROVIDER OR GROUP ON THE CLAIM.** | | |  |
|  | **I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.** | | |  |
|  | (A copy of this signature is as valid as the original.) | | |  |
|  |  |  |  |  |
| (PATIENT OR LEGAL GUARDIAN SIGNATURE) |  | (DATE) |
|  | | | |  |
|  | ***Children 14 years of age and older must sign below.*** | | |  |
|  | **I hereby authorize release of information necessary to file a claim with the insurance company, and ASSIGN BENEFITS, OTHERWISE PAYABLE TO THE POLICY HOLDER, TO THE PROVIDER OR GROUP ON THE CLAIM.** | | |  |
|  | (A copy of this signature is as valid as the original.) | | |  |
|  |  |  |  |  |
| (MINOR 14 YEARS OF AGE AND OLDER SIGNATURE) |  | (DATE) |

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|  | **YOUR PRIVACY** | | |  |
|  | As Behavioral/Mental Health providers, we may at times consult with other psychologists, counselors, or mental health providers. During these consultations, your anonymity will be protected. | | |  |
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| (PATIENT OR LEGAL GUARDIAN SIGNATURE) |  | (DATE) |
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|  | **PSYCHOTHERAPIST-PATIENT SERVICE AGREEMENT** | | |  |
|  | (If printing this form off of our website, click on “TREASURE VALLEY PSYCHOLOGICAL SERVICES HIPAA” link to read this document prior to signing this block. Otherwise, you will be provided a copy at our office.) | | |  |
|  | Your signature indicates you have read or had the opportunity to read the information in the HIPAA document, and agree to abide by its terms and conditions during your professional relationship with our facility. | | |  |
|  |  |  |  |  |
| (PATIENT OR LEGAL GUARDIAN SIGNATURE) |  | (DATE) |
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|  | **CANCELLATION POLICY - *READ FULLY***  **WE CHARGE $75, PER HOUR OF APPOINTMENT TIME, FOR APPOINTMENTS NOT KEPT, OR CANCELLED WITHOUT 24 HOURS ADVANCE NOTICE (LATE CANCELLATION).**   * We do NOT make or provide “reminder calls” for your appointments. | | |  |
|  | I acknowledge and understand this 24-hour appointment no-show and late-cancellation policy. I understand that I will be billed $75 directly, for any appointments I do not show up for, or that I cancel inside of 24 hours prior to my appointment time.  **I understand:**   * **Two consecutive unexcused appointments or three unexcused appointments in a calendar quarter constitute grounds for dismissal from service due to lack of client activity.** | | |  |
|  |  |  |  |  |
| (PATIENT/LEGAL GUARDIAN/GUARANTOR SIGNATURE) |  | (DATE) |
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|  | **ADDITIONAL ADMINISTRATIVE FEES WE CHARGE/BILED TO PATIENT:**   1. Letter writing, E-mails, Electronic communication or Telephone calls on behalf of patient/client: billed at $175/hour after the first 5 min. 2. Copying notes, assessments or other legal documents (requires written request):    1. 1-20 pages: $2.50 per page, single sided    2. 21-60 pages: $0.15 per page, single sided 3. Mail: bill/charge for excessive postage costs. | | |  |
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| (PATIENT OR LEGAL GUARDIAN SIGNATURE) |  | (DATE) |
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