Assessment and Psychotherapy Services, Inc.

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FORENSIC REGISTRATION FORM

(Please Print)

Today's date:	Doctor's Name:

PATIENT INFORMATION

Patient's Last name	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow

Race: ☐ Caucasian ☐ African American/Black ☐ Native American ☐ Asian ☐ Hispanic/Latin American ☐ Other	How many times married:	Social Security no.:	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	City:	State:	Zip Code:

Home phone no.: ( )	Cell phone no.: ( )	Email Address:

Employer:	Employer phone no.: ( )

Education: Highest grade completed:	Degree:	Have you been seen here before: ☐ Yes, if so what year? ☐ No

CRIMINAL INFORMATION

(Please give your insurance card and driver's license or state identification to the receptionist.)

Who is your Attorney:	Attorney phone no.: ( )

Please list current charge (s): _____

_____

Do you have any prior charges? ☐Yes ☐ No If yes, what are they? _____

_____

_____

IN CASE OF AN EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Please ask to sign a Release Of Information form for your Attorney and/or responsible parties.

The above information is true to the best of my knowledge.

Patient/Guardian signature	**Date**

OFFICE HOURS

Our office is open from 8:30 a.m.to 5:00 p.m., Monday through Friday. After 5:00 p.m. during the week, on weekends, and on holidays, the answering service will take messages and relay them to your doctor. The answering service should be utilized **ONLY** for **URGENT** problems that need resolution prior to the next work day.

A **No-Show or Late Cancellation Fee of $100** will be billed to you if you do not give at least 24 business hours notice prior to cancellation of your appointment. **Initials**_____

TELEPHONE CALLS, TEXT MESSAGES, CORRESPONDENCES

If you have any questions concerning your condition, therapy, scheduling appointments, or treatment, please call the office during normal working hours. Many of your questions can be answered by the office staff; however if you need to speak to your doctor, the receptionist will take a message and your call will be returned as soon as possible. **NOTE** if you call your Doctor directly, you **WILL** be billed for the time you are on the phone with the doctor. The doctors will not take telephone calls while treating other patients, except for emergency situations.

Telephone Consultations, Text Messages, and Correspondences are billed separately, and are not covered by insurance.

Initials_____

PARENTS

Our office has a play room for children. **Note** there are small objects in the play room that children can easily put in their mouth. If you child is under the age of five, they can not be left unattended. It is not the staff's responsibility to watch your child/children while you are in a session with your doctor. Please make pre-arranged child care or take your child into the session with you.

CURRENT OR PAST MEDICATIONS

Medications	**Dosage/Quantity**	**Condition**	**Prescribing Physician**

Have you ever received Psychological or Psychiatric help or treatment of any kind? ❑ Yes ❑ No
If yes, when? _____

Has the patient had any history of one of the following: ❑ Head injury, ❑ Traumatic injury, or ❑ Physical illness? If yes, please briefly explain_____

FAMILY HISTORY

Please list family members living with patient

NAME	AGE	GRADE/OCCUPATION	RELATIONSHIP

1. Is there a history of anxiety in the following biological family members?

Father	Yes	No	Unknown
Mother	Yes	No	Unknown
Siblings (brother/sister)	Yes	No	Unknown
Children (son/daughter)	Yes	No	Unknown
Grandparent (if so, maternal or paternal)	Yes	No	Unknown
Aunts/Uncles	Yes	No	Unknown

2. Is there a history of Bipolar I or Bipolar II Disorder in the following biological family members?

Father	Yes	No	Unknown
Mother	Yes	No	Unknown
Siblings (brother/sister)	Yes	No	Unknown
Children (son/daughter)	Yes	No	Unknown
Grandparent (if so, maternal or paternal)	Yes	No	Unknown
Aunts/Uncles	Yes	No	Unknown

3. Is there a history of major depression in the following biological family members?

Father	Yes	No	Unknown
Mother	Yes	No	Unknown
Siblings (brother/sister)	Yes	No	Unknown
Children (son/daughter)	Yes	No	Unknown
Grandparents (if so, maternal or paternal)	Yes	No	Unknown
Aunts/Uncles	Yes	No	Unknown

4. Is there a history of psychosis in the following biological family members? (radical changes in personality, impaired functioning, or nonexistent sense of objective reality)

Father	Yes	No	Unknown
Mother	Yes	No	Unknown
Siblings (brother/sister)	Yes	No	Unknown
Children (son/daughter)	Yes	No	Unknown
Grandparent (if ,so maternal or paternal)	Yes	No	Unknown
Aunts/Uncles	Yes	No	Unknown

PATIENT PRESENTING PROBLEMS

Please check ☑ the following that applies to the patient. He or she had or has problems with **thoughts** of:

- ❑ Not being good enough
- ❑ Not being cared about
- ❑ Not fitting in
- ❑ Being under pressure
- ❑ Being rejected
- ❑ Feeling abandoned
- ❑ Being a failure
- ❑ Being unattractive
- ❑ Being overweight
- ❑ Hopelessness/Helplessness
- ❑ Not knowing my identity
- ❑ Hearing voices or sounds others can't hear
- ❑ Having special powers
- ❑ Being superior or privileged
- ❑ Being in danger
- ❑ Being followed or spied on
- ❑ Revenge/getting even
- ❑ Racing ideas
- ❑ Being a bad or evil person
- ❑ Flashbacks of past trauma
- ❑ Hurting myself/others
- ❑ Killing myself/others
- ❑ Not being real
- ❑ Sexual preoccupation

Please check ☑ the following that apply to the patient. He or she has problems with **feelings** of:

- ❑ Guilt
- ❑ Apathy/indifference
- ❑ Boredom
- ❑ Intense loneliness
- ❑ Intense sadness
- ❑ Lack of confidence
- ❑ Hate
- ❑ Rage
- ❑ Tension
- ❑ Anger
- ❑ Fatigue
- ❑ Insecurity
- ❑ Depression
- ❑ Irritability
- ❑ Intense frustration
- ❑ Helplessness
- ❑ Being out of control
- ❑ Restlessness
- ❑ Being under pressure
- ❑ Anxiety/apprehension
- ❑ Specific fears/phobias
- ❑ Obsessiveness
- ❑ Mistrust/suspiciousness

Please check ☑ the following that apply to the patient. He or she had or has problem with the following **behaviors**:

- ❑ Aggression/fighting
- ❑ Stealing
- ❑ Vandalism
- ❑ Fire setting
- ❑ Alcohol abuse
- ❑ Alcohol addiction
- ❑ Arguing
- ❑ Eating
- ❑ Gambling
- ❑ Child abuse and/or neglect
- ❑ Bed wetting
- ❑ Compulsions
- ❑ Irresponsibility
- ❑ Inefficiency
- ❑ Making decisions
- ❑ Avoidance
- ❑ Procrastinating
- ❑ Temper
- ❑ Forgetting
- ❑ Using drugs, which drugs:
- ❑ Impulsiveness
- ❑ Running away
- ❑ Being oppositional/rebellious
- ❑ Masochistic acts
- ❑ Self-mutilation/injuring self
- ❑ Suicidal
- ❑ Bossing or controlling others
- ❑ Sadistic acts
- ❑ Homicidal acts
- ❑ Perfectionism
- ❑ Socializing with others
- ❑ Helping others too much
- ❑ Taking the blame
- ❑ Sleeping
- ❑ Lying
- ❑ Attention/concentration
- ❑ Self-defeating acts
- ❑ Being too dependent

Other:	❑ Gender identity	❑ Relationship	❑ Parenting	❑ Custody
❑ Family	❑ Marital	❑ Divorce	❑ Job related	❑ Financial
❑ School/education related	❑Learning disability	❑ ADD/ADHD	❑ Physical/medical related	

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my mental health care provider or employee of Assessment and Psychotherapy Services, Inc.

Please print

Last Name	First name	M.I.	DOB

Home Phone no.: ( )	Cell Phone no.: ( )	Employer phone no.: ( )

Do we have permission to leave the following information on your home, cell, or work phone answering machine or voicemail?	Appointment Information ❑ Yes ❑ No	Billing Information ❑ Yes ❑ No

I give permission to share the following information with the person(s) listed below:

Name:	Relationship:	Telephone no: ( )	Appointment ❑ Yes ❑ No	Billing ❑ Yes ❑ No
Name:	Relationship:	Telephone no.: ( )	Appointment ❑ Yes ❑ No	Billing ❑ Yes ❑ No

Please note medical information will not be shared unless a separate Release of Information form is completed.

Patient/Guardian signature	***Date***

FEE SCHEDULE AND FINACIAL AGREEMENT	
Therapy	
Diagnostic Interview	$240.00 per hour
Individual Psychotherapy (45 minutes)	$180.00 per session
Lengthy Complex Psychotherapy (60 minutes)	$240.00 per session
Psychological Testing	$240.00 per unit/hour
Services not covered by insurance	
No Show/Late Cancellation fees **(less than 24 business hours notice)**	$100.00
Telephone consultations, Emails, Text Messages, Correspondence	$60.00 (every 15 minutes)
Review of Records	$60.00 (every 15 minutes)
Administration and Copying	$1.00 (per page)
Criminal and Civil Cases	
Clinical Interview	$240.00 per hour
Expert Witness and Depositions	$300.00 per hour
Travel	$300.00 per hour
Psychological Testing	$240.00 per unit/hour
No Show/Late Cancellation fees **(less than 24 business hours notice.)**	$100.00

HIPPA PATIENT CONSENT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. A complete description of Assessment & Psychotherapy Services' Notice of Privacy Practices uses and disclosures are posted in the reception area.

PATIENTS WITH INSURANCE

I understand that I am responsible for any balance not paid by my insurance company. These include but are not limited to co-payments, deductibles, and percentages that my insurance company does not cover and fees considered not reasonable and customary. I also understand that if any changes in insurance coverage occur, it is my responsibility to notify the office immediately to avoid non-payment. I understand that I am responsible for obtaining authorization from my insurance carrier. I understand that I am responsible for all co-pays, deductibles, and for services that may or may not be covered by my insurance carrier. I understand that payment is expected at the time services are rendered.

PATIENTS WITHOUT INSURANCE

Refer to the fee schedule above. I understand that payment is due at the time of the appointment and I am responsible for paying for the services at that time. I understand that if my doctor quotes a retainer, I am responsible to provide that payment before work begins and that my account is paid in full before any work is produced on my behalf.

COLLECTION PROCEDURE

If my address or insurance has changed, I understand that it is my responsibility to notify this office immediately. I have read and understand the above financial agreements and will fully comply. I also understand that if my account becomes delinquent, I am responsible for a monthly $5.00 billing fee and my account could be turned over to a collection agency. I am subject to the cost of the collection agency fees and other charges incurred.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance company benefits to be paid directly to Assessment & Psychotherapy Services, Inc. (APS, Inc.) and/or the individual practitioner. I authorize APS, Inc. and/or the individual practitioner to release pertinent information such as diagnosis, date(s) of services (s), treatment plan(s), description of impairment, progress of therapy, case notes, and summaries to my insurance company and/or other party payers in order to process the claims(s). I authorize the use of this signature on all insurance submissions. I understand that I am responsible for those services, which are not covered by my insurance policy.

_____ _____ _____

Patient or Responsible Party Signature Relationship Date

_____

Patient Name (Please Print)