



# Assessment and Psychotherapy Services, Inc.

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## REGISTRATION FORM

(Please Print)

Today's date:		Doctor's Name:	
<b>PATIENT INFORMATION</b>			
Patient's Last name	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
			Marital status (circle one) Single / Mar / Div / Sep / Widow
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American/Black <input type="checkbox"/> Native American	<input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latin American <input type="checkbox"/> Other	How many times married:	Social Security no.:
		Birth date: / /	Age:
		Sex: <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Yes, if so what year? <input type="checkbox"/> No	How did you hear about us?
<b>INSURANCE INFORMATION</b>			
(Please give your insurance card and driver's license or state identification to the receptionist.)			
Policy Holder Name:	Birth date: / /	Address (if different):	Home phone no.: ( )
Employer:	Employer address:		Employer phone no.: ( )
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of primary insurance company	Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
	Subscriber's S.S. no.:	Birth date: / /	Group no.:
		Policy no.:	Co-payment: \$
Name of secondary insurance (if applicable):	Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
	Subscriber's name:		Group no.:
		Policy no.:	
Subscriber's S.S. no.:	Birth date: / /	Co-payment: \$	
<b>IN CASE OF AN EMERGENCY</b>			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
<b>Please ask to sign a Release Of Information form for your Primary Care Physician or referring doctor.</b>			
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Assessment & Psychotherapy Services and/or the individual practitioner. I understand that I am financially responsible for any balance. I also authorize Assessment & Psychotherapy Services or insurance company to release any information required to process my claims.			
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 your 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:

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

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

- |  |                                     |   |  |
|--|-------------------------------------|---|--|
| <input type="checkbox"/> Guilt               | <input type="checkbox"/> Hate       | <input type="checkbox"/> Depression           | <input type="checkbox"/> Being under pressure    |
| <input type="checkbox"/> Apathy/Indifference | <input type="checkbox"/> Rage       | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Anxiety/apprehension    |
| <input type="checkbox"/> Boredom             | <input type="checkbox"/> Tension    | <input type="checkbox"/> Intense frustration  | <input type="checkbox"/> Specific fears/phobias  |
| <input type="checkbox"/> Intense loneliness  | <input type="checkbox"/> Anger      | <input type="checkbox"/> Helplessness         | <input type="checkbox"/> Obsessiveness           |
| <input type="checkbox"/> Intense sadness     | <input type="checkbox"/> Fatigue    | <input type="checkbox"/> Being out of control | <input type="checkbox"/> Mistrust/suspiciousness |
| <input type="checkbox"/> Lack of confidence  | <input type="checkbox"/> Insecurity | <input type="checkbox"/> Restlessness         |  |

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

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

- |   |  |                                       |   |                                    |
|---|--|---------------------------------------|---|------------------------------------|
| <b>Other:</b>                                     | <input type="checkbox"/> Gender identity     | <input type="checkbox"/> Relationship | <input type="checkbox"/> Parenting                | <input type="checkbox"/> Custody   |
| <input type="checkbox"/> Family                   | <input type="checkbox"/> Marital             | <input type="checkbox"/> Divorce      | <input type="checkbox"/> Job related              | <input type="checkbox"/> Financial |
| <input type="checkbox"/> School/education related | <input type="checkbox"/> Learning disability | <input type="checkbox"/> ADD/ADHD     | <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Billing Information <input type="checkbox"/> Yes <input type="checkbox"/> No
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I give permission to share the following information with the person(s) listed below:

Name:	Relationship:	Telephone no: (    )	Appointment <input type="checkbox"/> Yes <input type="checkbox"/> No	Billing <input type="checkbox"/> Yes <input type="checkbox"/> No
Name:	Relationship:	Telephone no.: (    )	Appointment <input type="checkbox"/> Yes <input type="checkbox"/> No	Billing <input type="checkbox"/> Yes <input type="checkbox"/> No

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

<i>Patient/Guardian signature</i>	<i>Date</i>
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## 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)