

**Patient Registration**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

S.S. # \_\_\_\_\_ Email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Job Title: \_\_\_\_\_ Business Phone # \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Job Title \_\_\_\_\_

In case of emergency, who should we contact? \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship to patient? \_\_\_\_\_

Party responsible: \_\_\_\_\_

Referred by: \_\_\_\_\_

**Medications**

**Purpose**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Okay to contact me by: Email, Cell Phone, Home Phone, Work Phone, Other \_\_\_\_\_

**INSURANCE INFORMATION:**

Policy Holder \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Policy # \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

Name: \_\_\_\_\_

Primary Care Physician Phone # \_\_\_\_\_

\*\*\*\*Would you like for us to file your insurance for you? \_\_\_\_ Yes \_\_\_\_ No

**NOTICE: COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE**

**AUTHORIZATION AND RELEASE**

I hereby authorize the clinician to release all information necessary to secure payment of benefits from my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I fully understand that I am financially responsible for all charges whether or not paid by the insurance company.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

**CONFIDENTIAL**

**STATEMENT OF UNDERSTANDING/CONSENT**

**Consent for Care:**

I give full consent for the completion of my evaluation and provision of treatment and hypnotherapy (Medical Hypnoanalysis) as necessary, by the above named therapist, until otherwise notified. I understand that no promises have been made to me as to the result of this treatment or these procedures provided by this therapist. I realize that treatment is about change. If I have any questions about the following information or about anything related to my therapy, I will discuss this with the therapist.

**Confidentiality:**

You have the right to confidentiality in your therapy. Information concerning your therapy will not be disclosed without your prior written permission except for the following legal exceptions:

1. Life or safety of you or someone else is seriously threatened.
2. There is good reason to believe that you are abusing or neglecting a child or vulnerable adult or if you give me information about someone else who is doing this, child/adult protective services and/or the appropriate law enforcement agency must be notified.
3. Court ordered treatment.
4. An insurance benefit is filed and the claims payer requires information, i.e. diagnosis, types of treatment, dates, etc.
5. Parents or legal guardians of minors are legally privy to information disclosed during treatment. The therapist will discuss and clarify issues of privileged information regarding the child's treatment.

**Emergencies/Telephone Counseling:**

Medical and/or psychiatric emergencies should be directed to 911 if life or safety is threatened. The office phone number (512) 627-1396, is answered during business hours and by voice mail when I am not available. I will return your call as soon as possible during regular working hours and no later than the next working day. Emergency calls and telephone counseling is not covered by insurance. After hours and the weekend, please leave a message and I will get back to you on the next business day. If I cannot be reached and this is a life-threatening emergency, please go to the nearest ER; do not wait for me to return your call.

**Scheduling of appointments:**

Please conscientiously keep all scheduled appointments. If it is necessary to cancel an appointment, you must give at least 24 hours notice. Monday appointments must be canceled before noon on the preceding Friday. **You will be charged a fee for missed appointments or appointments canceled without 24 hours advanced notice (fee schedule).** Insurance companies DO NOT pay for missed appointments. Exceptions to this policy may be made for unforeseen emergencies, but must be discussed on a per case basis with the therapist. If you miss an appointment and do not contact the office about the reason, your next appointment is automatically cancelled.

**Fee policy:**

While the filing of insurance claims is a courtesy that is extended to you, all charges are ultimately your responsibility for the date of service. All co-payments, unmet deductible expenses, and services or charges not covered by insurance are due at the time of service. Any returned checks are subject to a \$20 charge. Those who have out-of-network benefits must pay the full fee upfront and have the insurance company reimburse them. Should your account be referred for collection, you agree to pay 6% interest plus a \$25 collection fee and reasonable attorney fees and/or court costs.

**Fees for services:**

Initial diagnostic evaluation - \$125	Missed appointments - <b>full fee</b>
Individual psychotherapy (50 mm) \$100	Consultation and training fee by contract
Family psychotherapy \$100	Telephone consultation - \$80/hr., rounded to the nearest 15 mm.
Legal consult \$200.00.	Fees for other services provided upon request

At times, I may work with other therapists or share office space with another therapist, but at all times we are independently practicing professionals who only share office space. While I may share office space, I am completely independent in providing you with clinical service, and I alone am fully responsible for those services. My professional records are separately maintained, and no other therapist can have access to them without your specific, written permission.

**I UNDERSTAND AND AGREE TO THE ABOVE TERMS.**

**Patient's Name:** \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name