

**Patient Registration/Patient Rights and Responsibilities**

Please fill out this form, read the *Patient Rights and Responsibilities* (on the back of this form), and sign where indicated.

Today's date: \_\_\_\_\_

**Patient Information:**

Soc Sec #: \_\_\_\_\_ Marital Status: S M Partner Sep Div Wid Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ Mailing Address (if different) \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: NC Zip Code: \_\_\_\_\_

Drivers License #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ May I call at Home? \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

Spouse's/Partner's Name: \_\_\_\_\_ Sp/Partner Employer: \_\_\_\_\_ Sp/Partner DOB: \_\_\_\_\_

Referred By: Insurance, Doctor, EAP, Self, Other (circle one) Referral Name: \_\_\_\_\_

**If You Are A Dependent, Complete The Following:**

Both Parents Names: \_\_\_\_\_

School Name: \_\_\_\_\_ Address: \_\_\_\_\_ Grade: \_\_\_\_\_

**Insurance Information: (Please give your insurance card to the counselor)**

Primary Insurance Co: \_\_\_\_\_ Group Number: \_\_\_\_\_ Member ID: \_\_\_\_\_

Auth. #: \_\_\_\_\_ Deductible: \$ \_\_\_\_\_ Co-payment: \$ \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ Group \_\_\_\_\_

Office Phone No: \_\_\_\_\_ Address \_\_\_\_\_

**Medications Prescribed:** \_\_\_\_\_

**State The Reason You Are Here Today:** \_\_\_\_\_

Are you required by your school, your employer, a judge, or a probation officer to have this appointment? Yes No

Is this problem related to an accident or injury? Yes No Is it work related? Yes No

**Prior Treatment History:**

Psychiatric Inpatient? Yes No Psychiatric Outpatient? Yes No

Substance Abuse Inpatient? Yes No Substance Outpatient? Yes No

Name(s) of Facilities where have you been hospitalized: \_\_\_\_\_

I certify that the above information is correct and that I have read and undersigned the *Patient Rights and Responsibilities* on the back of this form. I understand that payment is to be made at the time of the session, and that I am financially responsible for all schedule appointments unless a minimum of 24 hours notice is given. I also authorize my **Insurer** and/or **Counselor** to release my treatment records, as required, to my primary care physician (if an HMO patient). This release will terminate one year from my last appointment unless a written notice for extension is given.

**I understand that Debit and Credits Cards are NOT ACCEPTED for payment; that Cash or personal checks are acceptable for payment and is expected at the beginning of each session.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness or co-patient: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Rights and Responsibilities

### 1. Patient Relations

All patients have the right to be treated in a courteous, considerate, and dignified manner. If you have any issue that cannot be resolved with your clinician, please call your insurance case manager or patient relations representative at your local insurance office. If you are not satisfied with results at the local office, call your insurance's corporate patient relations staff at the number[s] listed on your insurance card or in your insurance benefits package.

### 2. Confidentiality

Privacy and confidentiality are of the utmost importance to the clinical relationship. Please feel free to discuss the legal limitations of confidentiality with your clinician. Your insurance is legally required to carry out quality assurance practices, and, under some managed care plans, your insurance will provide your primary care physician with information related to your case. Your insurance will follow these procedures unless otherwise notified by you, in writing.

Should your insurance or any of its constituents be subpoenaed, your clinician will normally provide the requested information, whether or not the information is favorable to the undersigned. In the event of subpoena or attorney's request, it is fully understood that your clinician *will* charge the patient up to **\$100.00** per hour for reports, court appearance(s), travel or any costs not reimbursed by insurance companies.

### 3. Financial

Patients are responsible for payment of all applicable fees at the time of the session. If you are a parent or guardian of a minor patient, all costs not covered by their insurance company will be your responsibility. The charge for your initial assessment is **\$85.00** and **\$85.00** for each additional session. Sessions are **fifty (50) minutes** in duration. Payment at the beginning of each session is preferred. **Cash or personal checks are acceptable for payment. Debit and Credits Cards are NOT accepted for payment.** Your clinician will provide you with a receipt at the conclusion of each session and for each payment. If your clinician is providing services to you through your Employee Assistance Program, he will follow the service agreement specific to your EAP.

### Managed Care Patients

Patients are responsible for payment of co-pays at the time of the session. If you miss more than two co-payments, your eligibility for insurance authorized outpatient services may be jeopardized. If you are unable to pay, please discuss this with your clinician and/or insurance case manager. If you exhaust your benefit, you may make private arrangements with your clinician to continue care of, or ask him/her, or your insurance, to make alternate arrangements.

### 4. Appointments

Your insurance and your clinician will make every effort to arrange appointment times that are convenient for you. Specific hours vary, but generally are during normal business hours. Appointments at other times are available for special needs.

In the event that you must cancel an appointment, please call your clinician at least 24 hours in advance. Failure to give adequate notice may result in your being billed for the appointment.

### 5. Authorization for Services - Managed Care Plans

In accordance with your insurance plan, your insurance must pre-approve all mental health and chemical dependency services. Non-compliance could lead to denial of benefits. Insurance approved clinicians, facilities and hospitals, must provide outpatient and inpatient services. Calling your insurance from 9:00 A.M. to 5:00 P.M., Monday through Friday can arrange for routine services. Calling your insurance, 24 hours per day, 7 days per week, can access emergency services.

### 6. Exclusions

Some insurance plans do not cover involuntary or court-ordered treatment. Psychological testing may or may not be covered under your insurance plan. Services generally not covered include: 1.) Psychological/Educational testing for children requested by or for a school system to assist a child in his or her emotional or academic development; 2.) Any psychological services required for fulfilling a legal evaluation. Exclusions include testing, report writing, counseling and psychotherapy or court testimony including evaluations in criminal, domestic and custody situations, as well as situations involving psychological injury where there is civil litigation; 3.) Developmental disabilities; 4.) Career or vocational testing; and 5.) Testing as required by law to fulfill certain job requirements such as those for police or security guards. Testing or therapy not covered by insurance can be arranged for privately. Please consult your clinician.

Signature \_\_\_\_\_ Date \_\_\_\_\_