Adult Patient Registration

I. **Patient Information:** Date: _____

A. Basic Demographic Information:

Name: _____
Last First Middle

Sex: _____ Age: _____ Date of Birth: ____/_____/_____ Social Security # _____ - _____ - _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

E-mail: _____ Work Phone: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

_____

B. Family Life:

1. Name of Spouse/Partner:	Relationship:
Home address:	Date of Birth:
	Home Phone:
Occupation:	Cell Phone:
Employer:	Work Phone:
Who is responsible for payment of the bill?	
Social Security # of Guarantor/Payer - -	

2. Please list all members of your immediate family and/or people living in your home			
Name	Age	Relationship	Occupation

II. Financial Information:

A. What method of payment will be used to pay for services provided? (Initial as indicated)

____I am paying completely out-of-pocket.
____I am using my health insurance benefits.

Health Insurance Company: _____

Name of Policy Holder: _____ Date of Birth: _____/_____/_____

Relationship to patient: _____

Insurance ID#: _____ Group#: _____

Employed by: _____

B. Assignment and Release:

___ If choosing to self-pay:
I understand I am financially responsible for all services, charges and fees.

___ If using health insurance:
I hereby authorize my insurance benefits to be paid directly to *Poehailos, Dupont & Associates, PLC* for services rendered. I authorize the release of any information as required by my insurance company or other reimbursing agency. I understand I am financially responsible for the charges not covered by my insurance company.

C. Contract for Payment: Many of our patients find it convenient to put a credit card on file with us. This is especially helpful if you have a busy schedule or late appointment times.

Cardholder Name: _____

Visa/Mastercard (please circle) Number: _____

Expiration: _____ V-code (3-digit code on back of card): _____ Billing Zip Code: _____

___ I authorize my credit card to be billed for all copays, ancillary charges, fees and services rendered that are not covered by my health insurance benefits at Poehailos, Dupont & Associates, PLC.

_____ _____
Signature of Patient/Guardian/Guarantor Date

Adult Intake Questionnaire

I. Initial Thoughts:

A. Briefly describe your reason for seeking services. _____

B. Who referred you to us? _____

C. What are your goals/hopes for treatment? _____

II. Previous Mental Health Treatment:

A. What outpatient mental health services have you received? Please include names of clinicians, dates of treatment and nature of problem. _____

B. Have you ever been in a hospital for mental health/emotional problems? If so, when and where?

C. Have you ever been on medication for emotional/behavioral problems? If so, what and when?

III. Medical History:

A. Who is your current primary care physician?
Name: _____
Address: _____
_____
Phone Number: _____

B. What are any current (or significant past) medical problems for which you have been treated?

C. What medications/dosages are you currently on? _____

Any medication allergies? _____

_____

Any other allergies? _____

_____

D. Have you ever had to undergo surgery? Sustained any significant injuries (e.g. head injury, broken bones)? Lost consciousness? Had a seizure? If so, please describe.

_____
_____
_____
_____

E. Do you have a history of any developmental problems, including but not limited to problems during your mother's pregnancy or delivery? Were developmental milestones met on time?

_____
_____
_____
_____

F. Do you smoke? Use alcohol? Use substances? If so, please describe and indicate frequency of use.

_____
_____
_____

G. Do you have a family history of medical or mental health problems? Please describe.

_____
_____
_____

H. Is there any other medical information you feel is important?

_____
_____

IV. Psychosocial Information:

A. Education:
   a. What is your highest level of education? _____
   b. What degree did you earn? _____
   c. From which school? _____
   d. Did you ever receive special education services? Did you ever have to repeat any grades? If so, describe. _____
      _____
      _____

B. Spiritual Life:
   a. How important is religion in your life?
      ____ Very _____ Somewhat ____Not at All

b. If you are religious, what is your denomination? _____

c. What facility/church do you attend? _____

d. Who is your leader/pastor? _____

C. Have you ever been involved with the law? If so, describe. _____
_____
_____
_____

D. What do you consider to be the most significant stressors you have had to face in your life? Have you had to face abuse, death of a loved one, separation/divorce? _____
_____
_____
_____

E. Use this space to add any additional information you think is important. _____
_____
_____
_____

F. Please list some of your special interests or hobbies: _____
_____
_____

G. Please list some of your personal strengths and positive qualities: _____
_____
_____

V. Suggestions and Comments:

A. How did you hear about us? _____
_____

B. Do you have any suggestions/comments regarding this form and/or the registration process?
_____
_____
_____

Thank you for the time and attention you have devoted to this form. It will help us to better serve you.

INFORMED CONSENT

I certify that I have read and accept the above ***Patient Information*** regarding *PDA*'s philosophy and policies/procedures. I understand that it is my responsibility to ask any questions that I may have of my clinician before signing. I understand that we will begin with an assessment of my family's needs and that neither *PDA* nor I are under any obligation to continue with treatment from that point. If we do decide to enter into a treatment relationship, that relationship may be terminated at any point for reasons that my clinician would discuss with me, including failure to comply with treatment recommendations and failure to pay bills. Before terminating the relationship, efforts would be made to refer me to an alternative provider if I don't have one available. I further understand that mental health is not an exact science and that no guarantee can be made as to the result or success of my treatment. I understand that treatment involves a large commitment of time, money and energy. It will require a high level of dedication on my part, and may cause me/my family to experience many intense feelings, some of which may be painful. I understand that treatment often involves making significant changes and that every change potentially has both positive and negative effects. I understand the potential benefits and risks involved in seeking mental health treatment and am willing to proceed at this time. I understand that I can discuss any questions or concerns that I have with my clinician at any point. I have received a personal copy of this document for my reference.

I have also reviewed, agreed to, initialed, and signed the accompanying ***Summary of Financial Responsibility*** document.

_____ _____

Parent/Legal Guardian/Guarantor Witness

Date: _____ Date: _____

Effective 4/1/05; updated 3/1/07

Poehailos, Dupont & Associates, PLC

SUMMARY OF FINANCIAL RESPONSIBILITY

Unless other arrangements are made, **payment for sessions is due at the time of the session** (either **full fee** if you are paying privately, or your **co-payment** if we are billing your insurance company). Failure to pay at the time of service will result in an Administration Fee of $5.00. Fees are reflected on the ***Fee Schedule*****,** which is included in the intake packet available on our website or in the office.

Insurance is billed as a service to our patients; however, insurance companies do not guarantee payment and if insurance payments are not received **within 90 days** of service**, responsibility for payment switches to the guarantor.** Office staff and your clinician are available to discuss payment issues with you.

Please review and initial the following:

_____ I understand that insurance may be filed for me, but that I am ultimately responsible for payment of fees regardless of insurance coverage.

_____ I authorize the release of medical information required to process insurance claims and/or to complete Treatment Plans/Reviews required by insurance or managed care companies.

_____ I authorize payment from my insurance company to be made directly to the practice.

_____ I understand that I am responsible for informing the practice of changes in my insurance.

_____ I understand that I am responsible for obtaining proper (pre)authorization from my insurance company to use mental health benefits. I accept responsibility for payment if authorization is not obtained.

_____ I understand there may be a *Report Preparation* fee involved in my clinician completing a Treatment Plan or a *Telephone Consultation* fee involved in my clinician communicating with my insurance/managed care company.

_____ I understand that most insurance companies only reimburse for face-to-face services and that I am responsible for payment of any Ancillary Services requested/utilized during the course of treatment.

_____ I understand that I may be billed for any missed appointments unless I call to cancel at least 24 hours before my scheduled appointment.

_____ I understand that mailed, monthly bills are due at the time of receipt. Any bill not paid within the month of the date of billing will have an interest charge of 1% added to the bill, unless other arrangements are made.

_____ I understand I will be charged an administrative fee of five ($5.00) dollars if I do not pay my copay at the time of service.

Signed _____ **Date**_____

Effective 4/1/05; updated 03/01/07

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have reviewed, been provided with the opportunity to receive, or received a copy of Poehailos, Dupont & Associates Notice of Privacy Practices.

_____ _____
Signature of Patient or Guardian Date

_____
Name of Patient (if a minor)