CLIENT REGISTRATION FORM

PSYCHOLOGICAL ASSOCIATES OF THE BLACK HILLS, LLC

Welcome and thank you for choosing Psychological Associates of the Black Hills

DATE: _____

Are you a returning client? _____ If so, what was your last name then? _____Maiden Name: _____

CLIENT'S LEGAL NAME _____ **GOES BY:** _____

FIRST, MIDDLE, LAST

ADDRESS: _____

NUMBER & STREET APT. # CITY STATE ZIP

PHONE: Home (___) _____ Work (___) _____ Cell (___) _____

EMAIL ADDRESS: _____

REMINDER CALLS: Please choose one number that you would like to be reached at **#** _____

Is it OK to leave messages on your phone?: Yes_____ No_____

Others that may be contacted for scheduling: Name _____Relationship_____ Phone # _____

MARITAL STATUS: (circle one) N/A-CHILD SINGLE MARRIED DIVORCED SEPARATED WIDOWED LONG-TERM PARTNER

GENDER: _____ **AGE:** _____ **BIRTHDATE:** _____-_____-_____

REFERRED BY: _____ **PRIMARY PHYSICIAN:** _____

PLEASE LIST PAST THERAPY/TREATMENT/EVALUATION: (Name, approximate dates)

_____

EMPLOYER: _____**OCCUPATION:** _____

EMPLOYER ADDRESS: _____

SPOUSE'S NAME: _____ **BIRTHDATE:** _____ **SOC. SEC. #:** _____

SPOUSE'S EMPLOYER'S NAME & ADDRESS: _____

OCCUPATION: _____ **WORK PHONE:** _____

ADDITIONAL INFORMATION - <u>WHEN CLIENT IS A MINOR</u> (Only provide Information <u>not</u> given above)

NAME OF MOTHER: _____**DOB:** _____ **STEP-FATHER:** (if any) _____

ADDRESS: _____**HOME PHONE:** _____

EMPLOYER: _____**WORK PHONE:** _____ **OCCUPATION**: _____

EMPLOYER ADDRESS: _____

NAME OF FATHER: _____**DOB**: _____ **STEP-MOTHER**: (if any) _____

ADDRESS: _____ **HOME PHONE**: _____

EMPLOYER: _____**WORK PHONE:** _____ **OCCUPATION:** _____

EMPLOYER ADDRESS: _____

LEGAL GUARDIAN/S: (If other than parents) _____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT: _____

CHILD'S SCHOOL: _____ **GRADE**:_____

SCHOOL CONTACT PERSON: _____**TITLE:** _____

OTHER PEOPLE LIVING IN HOME:

NAME	AGE	RELATIONSHIP	NAME	AGE	RELATIONSHIP
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

<u>TURN THIS FORM OVER AND COMPLETE REVERSE SIDE**</u>**

PLEASE FILL IN COMPLETELY

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Carrier _____________________________________	Carrier ______________________________________
Policyholder ________________________________	Policyholder___________________________________
Policyholder's DOB _________Relationship____________	Policyholder's DOB ________Relationship___________
Policy # _____________________________________	Policy # _____________________________________
Group # ____________________________________	Group # ______________________________________
Policyholder's SS #______________________ _____	Policyholder's SS # ___________________________ ___

*****Payment Due at Time of Service**: Payment for your portion of charges is due at the time of service unless other arrangements have been made. Appointments must be cancelled at least 24 hours in advance, as you may be billed for missed or late cancelled appointments.

- ✓ **Please initial here to acknowledge you've been made aware of this policy.** ____________
- ✓ **Billing Information:** If our biller would need to contact you please provide a number to be reached at and who we can speak to: **Name: _______________________________ Phone Number: ______________________**

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If you have any questions about psychotherapy or our office policies, please ask before signing below. Your signature indicates that you have read our office policies and that you seek and agree to enter into mental health services under those conditions. You understand that no promises have been made to you as to the results of any treatment or procedure provided by this provider. Further, it indicates your understanding that Psychological Associates may terminate services if there is a lack of compliance with these policies or if we believe that you are not benefiting from treatment.

CONSENTS

1. **Consent for Evaluation and Treatment**: Consent is given for evaluation and treatment by the provider and Psychological Associates of the Black Hills. I understand that at times cases are staffed anonymously between the professional staff; I consent to this procedure. It is agreed that either the provider or I may discontinue evaluation, consultation and/or treatment at any time and that the client is free to accept or reject the services offered or provided.

3. **Assignment of Insurance Benefits / Payment Agreement:** Psychological Associates will file all insurance claims unless otherwise directed. In the event that a client or responsible party is entitled to insurance benefits of any type arising from any policy which insures the client or other liable person, those benefits are hereby assigned to the provider for credit toward bills. The client and/or responsible party shall be financially responsible for any charges not paid by insurance. If payment is not made directly to the provider, payment in full is due from the client or responsible party. The undersigned agrees to pay the provider the assessed charges, in full, at the time of service unless other arrangements have been authorized. Please note there will be a $50 fee on all NSF checks. Psychological Associates reserves the right to charge interest or late fees on statements and accounts that are past due and not paid in a timely manner. It is the client's/responsible party's responsibility to set up a payment plan if he/she cannot pay their statement or account in full.
   Note to separated/divorced parents: *Psychological Associates will* ***not*** *bill the other parent unless that parent makes arrangements with us. It is your responsibility to seek any reimbursement from that parent. If your child is a client, you are requested to inform the other parent that your child is receiving services at Psychological Associates.*

4. **Release of Information for Medical Insurance Coverage to Insurance, Managed Care or EAP Company**: In order to process and determine benefits payable, I hereby authorize my provider to release any necessary part of the client's record, as specified by the Notice of Privacy Practices, to any insurance carrier or entitlement program, which may be obligated to pay all or part of treatment charges. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall remain in effect and valid until this office receives a written revocation signed by the client or other authorized person. I certify that the information I have furnished is true and correct. Psychological Associates bills through a variety of companies. Check with office personnel for doctor specific contact numbers. Personal checks, that identify you, will be presented for deposit at your provider's financial institution.

5. **Consent for the use of Email and Texts:** Psychological Associates cannot guarantee, but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Psychological Associates is not liable for improper disclosure of confidential information that is not caused by intentional misconduct. By signing below the client and/or responsible party is acknowledging and consenting to receive non-encrypted email and text message communication.

6. **Notice of Privacy Practices: I acknowledge that I have received the Notice of Privacy Practices from Psychological Associates of the Black Hills.**

____ ________________________

Signature of Adult Client, or Minor Client's Parent or Guardian **DATE**

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FOR OFFICE USE ONLY Location __________________________ Therapist_____________________________________

INITIAL DX____