CLIENT REGISTRATION FORM PSYCHOLOGICAL ASSOCIATES OF THE BLACK HILLS, LLC

Revised 10/2018

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

DATE: _____

Are you a returning client? YES NO If yes, what was your last name when you were last seen here? _____

CLIENT'S LEGAL NAME: _____ **PREFERRED NAME:**_____

FIRST, MIDDLE, LAST

ADDRESS: _____

NUMBER & STREET APT NO. CITY SD ZIP

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

EMAIL ADDRESS: _____

BEST NUMBER FOR APPOINTMENT REMINDERS: (_____) _____ _____CALL OR _____TEXT

Others that may be contacted for scheduling: NAME: _____Phone: (_____) _____

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED LONG-TERM PARTNER

GENDER:_____ **BIRTHDATE:** _____/_____/_____ **AGE:** _____ **SS#:** _____-_____-_____

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

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

EMPLOYER: _____ **OCCUPATION:** _____

EMPLOYER ADDRESS: _____

SPOUSE' S NAME: _____ **SPOUSE'S DATE OF BIRTH:** _____/_____/_____

SPOUSE'S EMPLOYER: _____ **EMPLOYER CITY/STATE:** _____

SPOUSE'S PHONE: Home- (_____) _____ Work- (_____) _____ Cell- (_____) _____

ADDITIONAL INFORMATION-WHEN A CLIENT IS MINOR (Only provide information NOT given above)

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

ADDRESS: _____ **PHONE: (_____)** _____

EMPLOYER: _____ **OCCUPATION:** _____

EMPLOYER CITY/STATE: _____ **WORK PHONE: (_____)** _____

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

ADDRESS: _____ **PHONE: (_____)** _____

EMPLOYER: _____ **OCCUPATION:** _____

EMPLOYER CITY/STATE: _____ **WORK PHONE: (_____)** _____

LEGAL GUARDIAN(S) (if other than parents): _____

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

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

OTHER PEOPLE LIVING IN HOME:

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

*****TURN THIS FORM OVER AND COMPLETE REVERSE SIDE*****

PLEASE FILL IN COMPLETELY

PRIMARY INSURANCE

Carrier: _____

Policy Holder: _____

Policy Holder's DOB: _____/_____/_____

Relationship to Client: _____

Policy #: _____

Group #: _____

Policy Holder's SS#: _____-_____-_____

SECONDARY INSURANCE

Carrier: _____

Policy Holder: _____

Policy Holder's DOB: _____/_____/_____

Relationship to Client: _____

Policy #: _____

Group #: _____

Policy Holder's SS #: _____-_____-_____

*****PAYMENT DUE AT TIME OF SERVICE:** Payment for your portion of charges is due at the time of service unless other arrangements with the provider have been made. Appointments must be canceled at least 24 hours in advance or you may be billed for missed or late canceled appointments.

- ✓ **Please initial here to acknowledge you've been made aware of this policy: _____**
- ✓ **Who is responsible for payment of this account?: _____**
- ✓ **If our biller would need to contact you, what is the best name and number to reach? Is is ok to leave messages? Yes_____ No_____**

NAME: _____ **PHONE:** (_____) _____

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 mental health services under those conditions. You understand that no promises have been made regarding results of any treatment or procedure provided by the provider. Further, it indicates your understanding the Psychological Associates of the Black Hills may terminate services if there is a lack of compliance with these policies or if the provider believes you are not benefiting from treatment.

CONSENTS

1. **Consent for Evaluation and Treatment:** Consent is given for evaluation and treatment to 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.
2. **Assignment of Insurance Benefits/Payment Agreements:** Psychological Associates of the Black Hills or the providers' billers will file all insurance claims unless otherwise directed. If the 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 balances on the client account. 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 by insurance, payment, in full, is due from the client and/or responsible party. The undersigned agrees to pay the provider the assessed charges, in full, at time of service unless other arrangements have been authorized. Please note, there will be a $45.00 fee on all NSF checks. Psychological Associates of the Black Hills reserves the right to charge 1.5% interest and/or late fees on statements for accounts 60 days past due and not paid in a timely manner. It is the clients' and/or responsible parties' responsibility to set up a payment plan if they cannot pay their statement in full. If client's account is past due, records release may be postponed until payment is made on account.
   Note to Separated/Divorced Parents: *Psychological Associates of the Black Hills will NOT bill the other parent unless that parent coordinates with us. It is your responsibility to seek any reimbursement from the other parent. If your child is a client, you are requested to inform the other parent that your child is receiving services at Psychological Associates of the Black Hills.*
3. **Release of Information for Medical Insurance Coverage to Insurance, Managed Care, or EAP:** 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 of the Black Hills bills through a variety of companies. Check with office personnel for provider-specific contact numbers. Personal checks, that identify you, will be presented for deposit at your provider's financial institution.
4. **Consent for the use of Email and Texts:** Psychological Associates of the Black Hills cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text communications. By signing below the client and/or responsible party is acknowledging and consenting to receive non-encrypted email and text communications.
5. **Notice of Privacy Practices:** I acknowledge that I have received the Notice of Privacy Practices from Psychological Associates of the Black Hills.

_____ _____

SIGNATURE OF CLIENT OR RESPONSIBLE PARTY DATE

FOR OFFICE USE ONLY:

Location: _____ Therapist: _____

Initial DX: _____