

UNIVERSITY COUNSELING CENTER INC

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION											
Patient's last name:			First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		Marital status (circle one) Sin / Mar / Div / Sep / Widow / Partner		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?			(Former name):			Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Social Security no.:			Home phone no.: ()		Cell phone no.: ()		
P.O. box:		City:		State:		ZIP code:		Email address:			
Occupation:			Employer:				Employer phone no.: ()				
Today's date: / /			PCP (Primary Care Physician):				PCP phone no.: ()				
How were you referred to our office?" (please check all that apply):						<input type="checkbox"/> Dr. (name)		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Website		<input type="checkbox"/> Other (describe)	

INSURANCE INFORMATION									
(Please give your insurance card to the receptionist and fill out information on the insured if the insured is not the patient.)									
Person responsible for bill:		Birth date: / /		Address (if different):				Home phone no.: ()	
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /		Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Spouse	<input type="checkbox"/> Child		<input type="checkbox"/> Other (describe)				
Name of insurance (if applicable):			Subscriber's name:				Group no.:		Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other (describe)			
Name of secondary insurance (if applicable):			Subscriber's name:				Group no.:		Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other (describe)			

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize University Counseling Center or insurance company to release any information required to process my claims and to communicate with Primary Care Physician (PCP).

Patient/Guard/an signature: _____ Date: ____/____/_____

University Counseling Center Inc

OFFICE POLICIES, PROCEDURES AND FEES

PATIENT RIGHTS:

As a Patient, you have the right to receive available services individualized to your specific needs and provided in the least restrictive manner. You have the right to seek information and approve of therapeutic practices.

HIPPA:

I have been informed as to the new HIPPA Notice of Privacy Practices.

APPOINTMENTS:

Appointments can be scheduled as the therapist's time becomes available. Traditionally, an "hour" is considered to be approximately 45-50 minutes. The length of therapy depends on many factors and is decided between you and the therapist.

You must give at least 24 hours notice if you need to cancel or reschedule an appointment. You will be charged a "No Show" fee of \$25.00 for appointments made but not kept. Accounts must be settled before future appointments will be made. Be advised that a "Courtesy Call" to remind you of an appointment is a courtesy, not a requirement. It is the responsibility of the patient to maintain their appointments.

PROFESSIONAL FEES:

This office accepts cash or check and many types of health insurance. A receipt for payment will be provided upon your request. If there are any questions about financial procedures, please feel free to ask and financial policies will gladly be explained.

Payment for professional services is due in full at check-in time of your appointment. Psychotherapy fee per hour is \$175.00 first visit/\$150.00 following visits. Health insurance may cover mental health services. As a courtesy, this office can file your insurance claim if requested. Driver's license or equivalent ID and insurance card must be provided. Deductible, co-pay, or uncovered services are due in full at check-in time of your appointment if insurance authorization is approved prior to appointment. If your insurance denies payment on your account you will be responsible for payment. Payment is due in full at check-in time of your appointment unless previous arrangements have been made. Patients may file with their insurance company for reimbursement for insurances not accepted or filed by this office.

I understand and agree that I am responsible for the fees I incur for the professional services of University Counseling Center. If I fail to pay on my account, University Counseling Center has the right to turn my account over to a collection agency or attorney for collection.

A \$25.00 fee will be charged to your account if a check is returned from your bank for insufficient funds and payment will be due immediately for the amount of the check and the returned check fee.

ADDITIONAL SERVICE FEES

Please note that most insurance companies do not cover these Additional Service Fees and are your responsibility.

Reports - The time required to compose a report is charged to patients at a fee of \$100 unless paid by requesting party or can be done during your appointment time. University Counseling Center may decline to do legal reports.

Copies/Faxes - There is no charge to patients for a copy of their record needed by another physician to treat you; copies for other purposes are charged to the patient at a fee of \$1.00 per page for the first 25 pages and \$0.25 for additional pages unless paid by requesting party.

Telephone Calls - There is no charge for necessary phone calls (example calls: side-effects, presence of new or severe symptoms, lost medication, medication refills, need for a change in treatment). Note that a new appointment may be required before responding to calls. The time required for perfection service phone calls (example calls: talking to family members, consulting with your insurance company about treatment, medications, psychotherapy) is charged at a fee of \$150.00 per hour.

Court - Court related services must be prepaid and are nonrefundable.

AFTER HOURS EMERGENCY POLICY

If you have an emergency requiring immediate medical or mental health care attention, please dial 911. If it is not an emergency, please leave a message and we will return your call on the next business day.

TERMINATION OF SERVICE

University Counseling Center considers all cases to be closed (with or without notice) six (6) months after the last visit. Cases can be reopened by scheduling another appointment.

SIGNATURE

I have read and agreed to the Office Policies, Procedures and Fees

Patient/Guard/an **signature:** _____

Date: /___/___/_____

University Counseling Center Inc

NOTICE OF PRIVACY, CONSENT FOR EVALUATION, AND TREATMENT

Patient Name: _____ Parent/Guardian: _____

- 1) I understand the concepts and conditions of informed consent, privacy, and confidentiality.
- 2) I understand that I have the opportunity to discuss these concepts and conditions and to ask for clarification of parts, which I was concerned about or did not fully understand.
- 3) I understand that I will be informed of the goals, expectations, procedures, and benefits and possible risks involved in the evaluation and counseling process.
- 4) I understand that the process of counseling, psychotherapy, or evaluation is an interactive process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable, and at other times, very fulfilling. I understand that there are no guarantees of positive outcome for the therapy process.
- 5) I have the right to refuse or withdraw from any counseling, psychotherapy, or evaluation procedure or intervention unless otherwise specified by law.
- 6) I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
- 7) I understand that all communication will be private, legally privileged and confidential unless otherwise specified by the special laws presented below or unless I provide my written consent to a specific release of information. As a part of our day-to-day activities, University Counseling Center may need to use and disclose (share) your protected health care information for several purposes without first getting your written approval. Those purposes may include discussions with staff, your pharmacist and Primary Care Physician.
- 8) I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.

Please note the following exemptions to privacy, privileged communication, and confidentiality:

There are special laws that allow for the release of confidential or privileged information that have been developed in an effort to provide protection for the patient and the public in unusual circumstances. Information that the patient discloses may be released without consent to the appropriate parties involved.

- 1) *If there exists a danger or harm to the patient or someone else;*
- 2) *If the patient needs to be involuntarily hospitalized due to the debilitating effects of mental illness or alcoholism*
- 3) *If the patient is required to undergo a court ordered examination;*
- 4) *If the patient discloses information about the abuse or neglect of a child;*
- 5) *If the patient discloses information about the abuse, neglect, or exploitation of an aged or disabled adult;*
- 6) *If the patient's mental or emotional condition is being used as a legal defense or if a civil, criminal, or disciplinary action arises from a complaint filed in behalf of the patient against a mental health professional/n which case the disclosure and release of information shall be limited to that action.*

I received a copy of University Counseling Center's Notice of Privacy, Consent for Evaluation, and Treatment. I understand that if University Counseling Center uses my personal health information in a manner that is different than described by the Notice, University Counseling Center must first get my permission in writing.

I am accepting this Notice on behalf of: Myself
 Another person as his or her personal representative (parent, guardian, family member etc.)

Signature of Patient/Guardian/ Personal Representative: _____ Date _____

REQUEST FOR CONFIDENTIAL HANDLING OF HEALTH INFORMATION

I, _____ request that University Counseling Center handles my confidential health information in the following way:

- A. All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe the alternate means by which you prefer to receive your health information.
 U.S. Mail Telephone Call _____ Fax _____ Other _____
(Provide telephone number) (Provide fax number) (Write in)
- B. All reasonable requests to receive communication of your health information at alternative locations will be granted. Please complete the following section only if you want communications regarding your health information sent to an alternative address (other than your residence).

(Street Address) (City) (State) (Zip)

Patient/Guardian signature: _____ Date: _____

Have you had previous psychotherapy?

No

Yes, at Previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

Yes

No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication?

Yes No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your sleep habits? No Yes

If yes, check where applicable:

Sleeping too little Sleeping too much Poor quality sleep

Disturbing dreams Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? No Yes

If yes, check where applicable: Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months? No Yes

6. Do you regularly use alcohol? No Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

7. How often do you engage recreational drug use? Daily Weekly Monthly
 Rarely Never

8. Have you had suicidal thoughts recently?

Frequently Sometimes Rarely Never

Have you had them in the past?

Frequently Sometimes Rarely Never

9. Are you currently in a romantic relationship? No Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors:

Have you ever experienced:

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no

Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? No Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? No Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? No Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

<u>Difficulty</u>	<u>Family Member</u>
Depression	yes/no
Bipolar Disorder	yes/no
Anxiety Disorders	yes/no
Panic Attacks	yes/no
Schizophrenia	yes/no

Alcohol/Substance Abuse yes/no
Eating Disorders yes/no
Learning Disabilities yes/no
Trauma History yes/no
Suicide Attempts yes/no

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

PRESENT HOUSEHOLD

NAME	AGE	RELATIONSHIP	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____