Mental Health Associates

REGISTRATION
(Please Print)

Date: _____

Cell # (_____) _____ Home # (_____) _____ Email Address: _____

DOB: _____/_____/_____ Social Security #: _____

Sex: _____Male _____Female
_____ Transgender Male (M to F)
_____ Transgender Female (F to M)
_____ Genderqueer
_____ Other ____Decline

Patient: _____
FIRST MI LAST

Preferred Name: _____

Address: _____

_____
CITY STATE ZIP

Marital Status:

_____ Single _____ Married
_____ Widowed _____ Separated
_____ Divorced

P.O. Box: _____ Occupation: _____

Patient Employer: _____ Employer Phone #: _____

Employer Address: _____
CITY STATE ZIP

Spouse/Parent: _____DOB: _____/_____/_____ SSN#: _____

Address: _____
CITY STATE ZIP

Phone #: _____ Employer & Phone#: _____

Other Parent: _____DOB: _____/_____/_____ SSN#: _____

Address: _____
CITY STATE ZIP

Phone #: _____ Employer & Phone#: _____

Primary Insurance: _____

ID#: _____

Policy Holder Name: _____

DOB: _____/_____/_____

Secondary Insurance: _____

ID#: _____

Policy Holder Name: _____

DOB: _____/_____/_____

Primary Care Physician: _____

Whom Referred you: _____

*2212 Pierce St. Suite 100 * Sioux City, IA 51104 * 712-255-8323 * Fax 712-255-8287*

Mental Health Associates

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with

_____

Name of Insurance Company/Companies/EAP Company

and assign directly to Mental Health Associates, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor or therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____

Signature of Client or Personal Representative Date

MISSED APPOINTMENTS POLICY

Appointments are scheduled in advance so that your therapist can prepare and make the best use of your therapy time. When you cannot attend a scheduled session, you must call no later than the end of the preceding business day (5:00 p.m.) and cancel.

Appointments that you miss without calling ahead to cancel or miss altogether are very inconvenient and costly. Barring illness or other emergencies, appointments that are not cancelled appropriately will be billed $55 for the social workers and $62.50 for the psychologists.

If there are 3 unexcused missed appointments in a 6-month span of time; your therapist or psychologist can use their discretion to dismiss you from our clinic. A dismissal letter will be forwarded to you with a list of other providers with whom you could schedule an appointment.

Your cooperation and consideration in this matter are very much appreciated. It is important to remember that charges for missed or late cancelled appointments cannot be billed to your insurance carrier and must be paid solely by you.

I have read and understand the above policy.

TERMINATION POLICY

Clients who have not had a session in over 60 days (or within a mutually agreed upon time) will be considered inactive. It is always preferred to schedule a final session before ending therapy in order to review and evaluate the sessions and assess overall progress. Please be fully assured that anyone wishing to return to active therapy can do so by contacting the office to make arrangements to resume the therapeutic relationship.

Your signature below indicates that you have read both the Missed Appointment and Termination policy and agree to its terms.

_____

Signature of Client or Personal Representative Date

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Authorization, Consent, & Acknowledgement

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Mental Health Associates, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Mental Health Associates, LLC.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Mental Health Associates, LLC is not required to agree to the restrictions that I may request. However, if Mental Health Associates, LLC agrees to a restriction that I request, the restriction is binding on Mental Health Associates, LLC. I have the right to revoke this consent, in writing at any time, except to the extent that Mental Health Associates, LLC has taken action in reliance on this consent.

I understand I may request a copy of the *Notice of Patient Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Patient Privacy Practices* from time to time and that I may contact Mental Health Associates, LLC at any time at the address above to obtain a current copy of the *Notice of Patient Privacy Practices.*

Coordination of Treatment

☐ I give permission for my provider at Mental Health Associates, LLC to release mental health information for the purpose of coordination of care with my primary care physician and any other medical practitioners who provide care for me. *(If you check this box, please include these person/persons on the release of information)*

☐ I decline to release information to my primary care physician or other medical providers at this time

Advance Directives (Living Will)

☐ I currently have a Psychiatric Advance Directive.

☐ I do not have a Psychiatric Advance Directive. I understand I can follow up on this by logging on to www.nrc-pad.org . It is recommended that you seek legal counsel when completing this document. If such a document is completed, I will provide a copy to this office.

Print Patient Name _____

Relationship to Patient _____

_____

Signature of Client or Personal Representative Date

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Mental Health Associates

Client Rights and Informed Consent – Guideline

- I have chosen to receive treatment services and understand I may terminate therapy at any time, unless ordered by the court.
- I understand there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.
- I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my problems.
- I understand that records and information collected about me will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.
- I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.
- I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.
- I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
- I understand that I may be contacted by my health plan to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.
- I have read and had explained to me the **BASIC RIGHTS OF INDIVIDUALS** including:
  - The right to be informed of the various steps and activities involved in receiving services.
  - The right to share in the formation of the plan of care/treatment plan.
  - The right to confidentiality under federal and state laws relating to the receipt of services.
  - The right to humane care and protection from harm, abuse, or neglect without regard to race, color, religion, gender, sexual orientation, age, disability, or cultural background.
  - The right to make an informed decision whether to accept or refuse treatment.
  - The right to contact and consult with counsel at my expense.
  - The right to select practitioners of my choice at my expense.

I understand that my therapist, health plan representatives, and my primary care physician may exchange any and all information pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do no revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Personal Representative Date

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Child Information Form

CONFIDENTIAL

Note

The information you disclose on this form is for use by the provider to aid in better understanding your child's problems and developing an appropriate treatment plan for your child. This information will not be released to any other parties without your explicit consent or very exceptional circumstances. If you have any concerns about this, please discuss this with the provider.

Today's Date: _____

Child's Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Place of Birth: _____ SSN#: _____

Child's Ethnicity: _____

RESIDENCE:

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home (___) _____

Emergency Contact: _____ Relation to Client: _____

Phone: _____ Address: _____

EDUCATION: **AVERAGE GRADES:** _____

School(s) Location(s) Dates

_____

_____

_____

Problem Areas in School:

_____

_____

_____

By Whom Were You Referred? _____

OTHER CHILDREN:

Names Sex Age Relationship to Client

(Place a check by those living in the home)

IMPORTANT PEOPLE TO YOUR CHILD:

Name Age Education Occupation Comments (e.g. Health)

Father: _____

Mother: _____

Grandmother (P): _____

Grandfather (P): _____

Grandmother (M): _____

Grandfather (M): _____

Other Important People: (Friends, relatives, Etc.) _____

MEDICAL:

Physician: Name, Address & Phone:

Date Last Seen: _____ Last Physical: _____

Current and/or Chronic Medical Problems/Diseases/Conditions/Etc.: ☐ None

Allergies: ☐ None

Current prescription medications/dosage/start dates: ☐ None

PREVIOUS COUNSELING, PSYCHOTHERAPY, SUBSTANCE ABUSE OR OTHER MENTAL HEALTH SERVICES:

Names Profession City Dates Type

SUBSTANCE ABUSE HISTORY:

Substance	Amount	Frequency	Duration	1st Used	Last Used
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Other					

CHILD'S DEVELOPMENT:

Developmental History (developmental milestones met early, late or normal):

Peri-natal History (details of labor/delivery, problems, normal delivery, premature birth, etc.):

Prenatal History (problems encountered during pregnancy):

CONCERNS AND MISCELLANEOUS:

What are your main concerns?

COMMENTS: (Please provide any other information about yourself which may be helpful to us in understanding the situation. If you need more room, please use the backside of this paper):